

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE				LAST				2a. DATE OF DEATH				2b. HOUR			
1. DECEASED-NAME (Type or print) Janie M. Abramo								May Month 2 Day 1969 Year 4:30 P.M.							
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7/15/23		6. AGE (In years last birthday) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore									
10. CITY OR TOWN OF DEATH Reisterstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 308 Holly Hill Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Retail									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Reistertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 308 Holly Hill Road							
14. FATHER'S NAME First Middle Last Earl Witt				15. MOTHER'S MAIDEN NAME First Middle Last Nina											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-14-0620		17. INFORMANT Mr. Don S. Abramo		Address 308 Holly Hill Rd. 21136									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - colon & metastasis 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from April , 1968, to May 2 , 1969, that (I) (we) last saw the deceased alive on May 2 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE E. E. Mc. Williams		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 2, 1969									
22d. PHYSICIAN'S NAME (Type) E. E. Mc. Williams		22e. ADDRESS 11904 Reistertown Road. 21136													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/6/69		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.									
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge									

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HEADQUARTERS
WASHINGTON, D.C.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06415

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06412

1. DECEASED-NAME (Type or Print) Adam			First Middle Last Abramowski			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month May Day 8 Year 1969			2b. HOUR 3P M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 2, 1901		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month May Day 8 Year 1969		2d. HOUR 340 P M	
7a. BIRTHPLACE (State or foreign country) Poland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md.	
10. CITY OR TOWN OF DEATH Dundalk			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 1807 Maxwell Avenue						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Dundalk			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1807 Maxwell Ave.		
14. FATHER'S NAME First Julius Middle Abramowski Last 			15. MOTHER'S MAIDEN NAME First Julianna Middle Last Ulko			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 218-36-0708A			17. INFORMANT (Wife) Mrs. Eva Abramowski, 1807 Maxwell Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4124 IMMEDIATE CAUSE (a) A-S-C-E-V-Sion DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE M B Davis						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 5/9/69	
EXAMINER'S NAME (Type) Melvin B. Davis						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						6800 Mornington Road	
M.D.						ADDRESS (Street, city, town, or county) Dundalk, Md. 21222							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/12/69			23c. NAME OF CEMETERY OR CREMATORY Christ Lutheran Church Cem.			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						25a. REC'D BY REGISTRAR DATE MAY 14 1969			25b. REGISTRAR'S SIGNATURE Francis Judge				

Name	Address	City	State	Zip
John Doe	123 Main St	New York	NY	10001
Jane Smith	456 Elm St	Los Angeles	CA	90001
Bob Johnson	789 Oak St	Chicago	IL	60601
Alice Brown	101 Pine St	Houston	TX	77001
David Wilson	202 Cedar St	Phoenix	AZ	85001
Mary White	303 Birch St	San Antonio	TX	78101
James Green	404 Spruce St	Dallas	TX	75201
Susan Black	505 Ash St	San Diego	CA	92101
Michael Gray	606 Hickory St	Austin	TX	78701
Jennifer King	707 Maple St	Fort Worth	TX	76101
Christopher Lee	808 Poplar St	Jacksonville	FL	32201
Amanda Hall	909 Walnut St	Nashville	TN	37201
Daniel Young	1010 Chestnut St	Memphis	TN	38101
Elizabeth Scott	1111 Locust St	Portland	ME	04101

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06416					06413					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
Leonard Guy Ackley					5 Month 21 Day 69 Year			7:20AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Caucasian		11/3/10		58 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penna.		USA				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson			Greater Balto. Med. Center							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.		GlenArm		YES <input type="checkbox"/> NO <input type="checkbox"/>		Long Green Pike	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
ne			155 05 5535		family records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas										
157.9 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/17, 19 69, to 5/21, 19 69, that (I) (we) last saw the deceased alive on 5/21 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE							DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)							22e. ADDRESS		22c. DATE SIGNED	
Rudiger Breiteneker, M.D.							6701 North Charles Street		5/21/69	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
burial		5 24 69		Parkwood			Baltimore County, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
C.F. EVANS & SON 8802 HARTFORD RD				MAY 23 1969		[Signature]				

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<div> <div>1</div> <div>06417</div> <div>4124</div> </div> <div> <div>MD</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06414</div> </div>											
1. DECEASED-NAME (Type or print) Mildred R. Adkins						2a. DATE OF DEATH Month May Day 30 Year 1969			2b. HOUR 9 ^{PM}		
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 27, 1908			6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md.		
10. CITY OR TOWN OF DEATH Arbutus			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1345 Poplar Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY Telephone		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland			13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1345 Poplar Ave.				
14. FATHER'S NAME First Middle Last James E. Solt						15. MOTHER'S MAIDEN NAME First Middle Last Bertie L. Haller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Roland F. Adkins Address 1345 Poplar Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from July 27, 1908 , to 5/30, 1969 , that (I) (we) last saw the deceased alive on 5/30 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James D. Frederick M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/30/69			
22d. PHYSICIAN'S NAME (Type) J. N. Frederick						22e. ADDRESS 1311 Francis Ave. Balto. Md. 21227					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			23d. LOCATION (City or Town) (County) (State) Frederick Maryland				
24. FUNERAL DIRECTOR Ambrose Inc.						ADDRESS 1328 Sulphur Spring Rd.		25a. REC'D BY REGISTRAR DATE JUN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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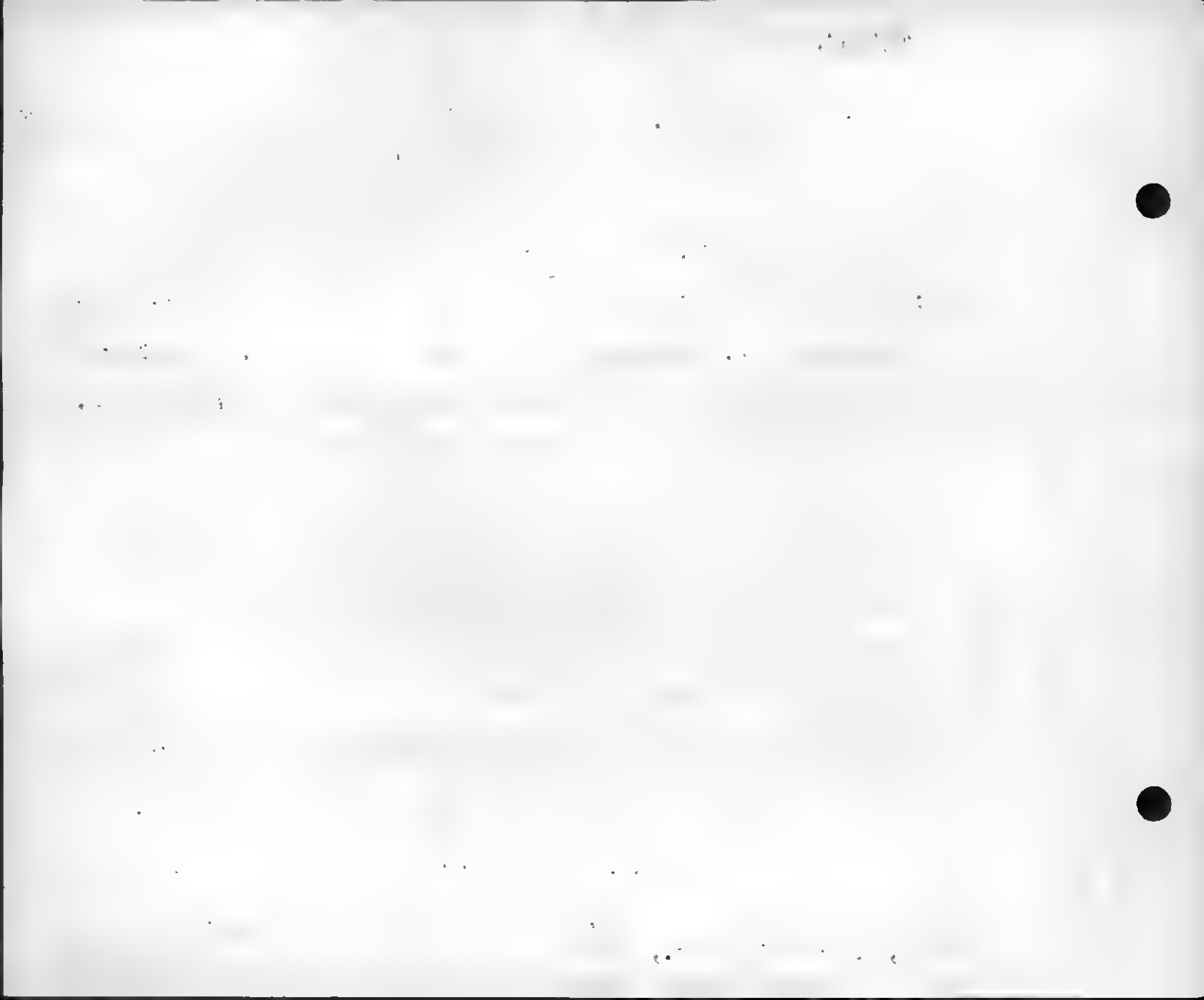
Release by the Medical Examiner Officer - Dr. Pillsbury

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR
John		Warner		Allwell				May 17 1969		11:45 AM
3. SEX	4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		4-10-08				64 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Baltimore		U.S.A.				Baltimore		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		St. Joseph Hospital				None				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland				Baltimore				539 Benninghaus Rd. #21212		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME First Middle Last		
George Allwell								Irene Bayne		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No		212-03-8716HA		Stephen S. Allwell 803 Evesham Avenue 21212						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema										
4124 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>5-17</u> , 19 <u>69</u> , to <u>5-17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Elfred A. Quitiquit</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED 5-17-69		
22d. PHYSICIAN'S NAME (Type) Elfred A. Quitiquit, M.D.								22e. ADDRESS 7620 York Road, Towson, Maryland 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5-21-1969		Holy Redeemer Cemetery		Baltimore, Maryland				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Wm. Cook-Brooks Towson 1050 York Road 21204				MAY 20 1969		<i>William Cook-Brooks</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
REGINA			P.		ANDREONE				May 4 1969		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Female			White		9-10-23		45 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2b. HOUR		
Maryland			USA				Baltimore		3:30aM		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph's Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) - STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Baltimore		Parksville				3001 Acton Rd. 21234		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Patrick J. Sullivan			Mary E. Holland								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
			218-12-6478		Fortunate Andreone		3001 Acton Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROX. MATE. INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cerebral hemorrhage											
4319 DUE TO, OR AS A CONSEQUENCE OF											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from May 1, 19 69, to May 4, 19 69, that (X) (we) last saw the deceased alive on May 4, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Tomboe									22c. DATE SIGNED 5-4-69		
22d. PHYSICIAN'S NAME (Type) Camilo L. Tomboc, M.D.						22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			5/7/69		New Cathedral Cemetery			Baltimore, Md			
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229						25a. REC'D BY REGISTRAR DATE MAY 6 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

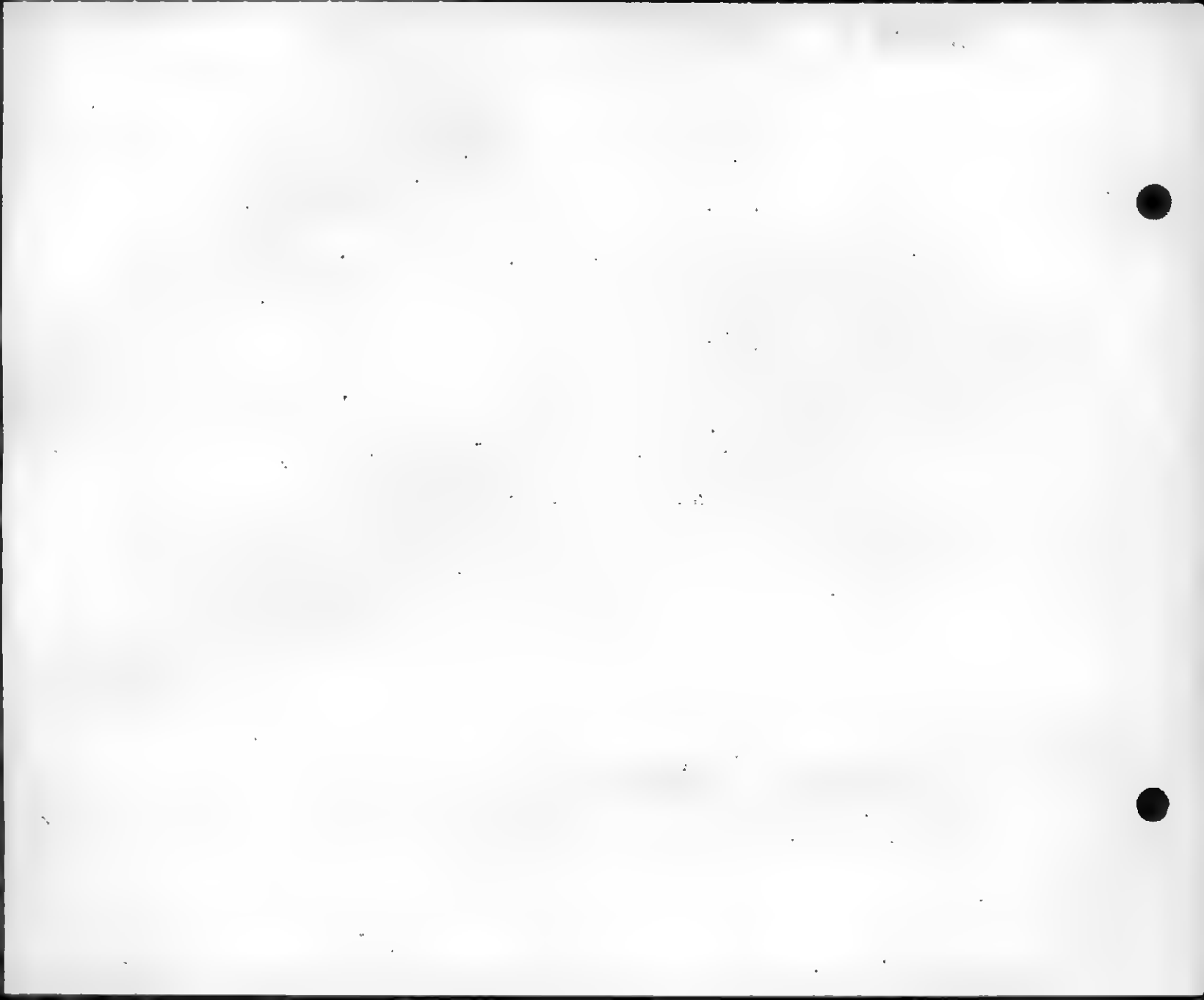
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06420

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06417

1 DECEASED NAME (Type or print)		First James	Middle Trimble	Last ARCHER	2a. DATE OF DEATH Month 5 Day 25 Year 69		2b. HOUR 2:42 P.M.
3 SEX Male		4 RACE White		5 DATE OF BIRTH February 13, 1958		6 AGE (In years last birthday) 11 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Owings Mills		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Alton Middle Eugene Last Archer		15 MOTHER'S MAIDEN NAME First Margaret Middle Lee Last GUN ELLS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO -----		17 INFORMANT Address Rosewood Records, Owings Mills, Md. 21117			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Asphyxia due to Acute Pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute & Chronic Pyelonephritis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>terminal</i> <i>1 year</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Whe institutionalized 10 yrs. Congenital Cerebral Defect 12 yrs.</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) (OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from January 4, 1960, to May 25, 1969, that (1) (we) last saw the deceased alive on 23 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (6) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard J. Jones</i>				22c. DATE SIGNED 26 May 69		22d. PHYSICIAN'S NAME (Type) ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-27-69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR <i>Thomas J. Hallis</i>		ADDRESS 500 University Blvd Silver Spring Md.		25a. REC'D BY REGISTRAR DATE JUN 2 1969		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>	

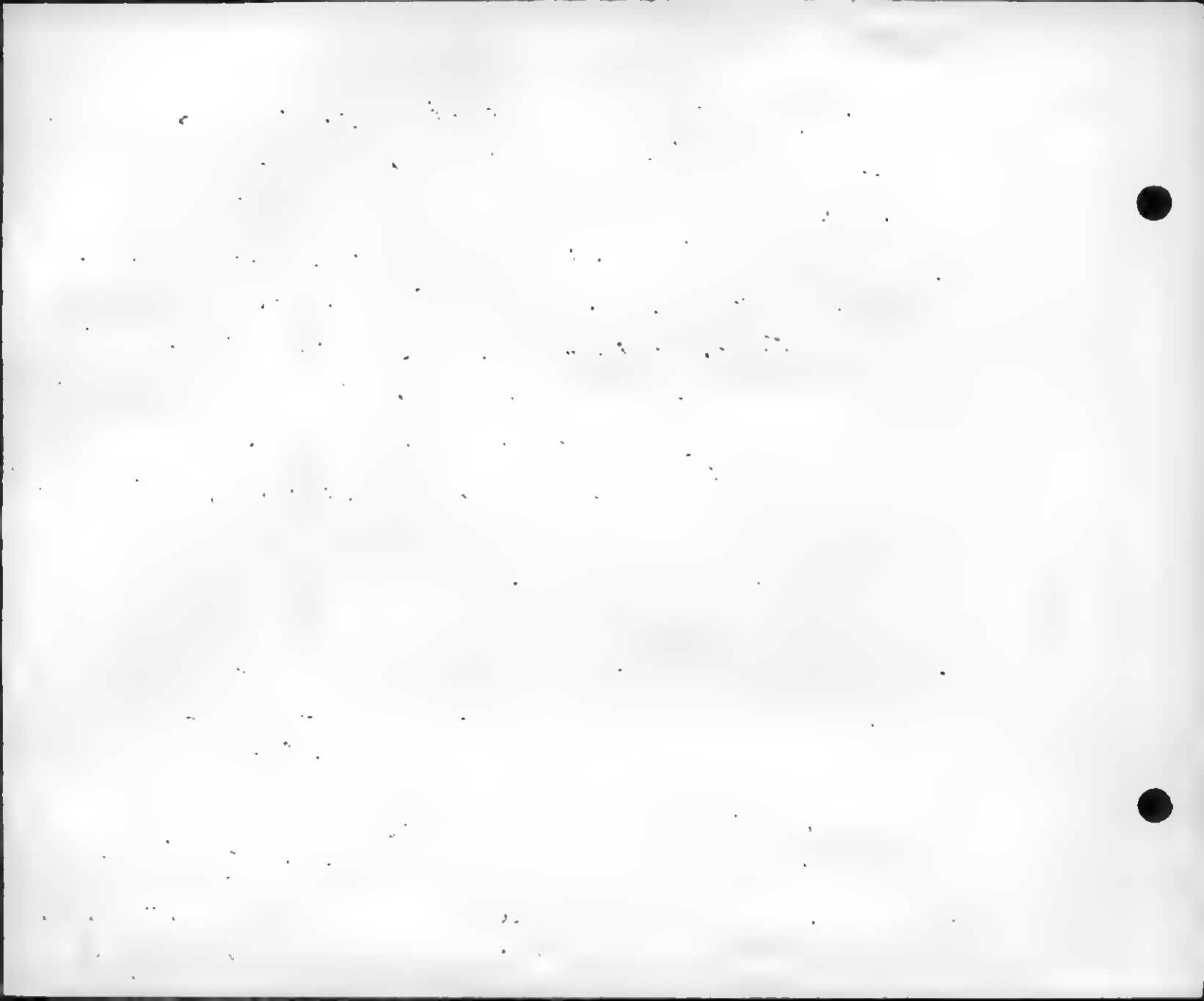


188X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06421		CERTIFICATE OF DEATH						06418			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
George WAYSAY ARMACOST						MAY 28 1969			9:30 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)			7. IF UNDER 24 MRS. MONTHS DAYS HOURS MIN.	
Male		White		May 7 1901			68 YRS.				
7a. BIRTH-PLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			USA						Baltimore Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hampstead			Black Rock Road			Carpenter			General		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Baltimore			Hampstead			Black Rock Road		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Joseph Franklin ARMACOST			Della ANN MARTIN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			215-05-9078A			Mrs. Wills ARMACOST			HAMPSTEAD MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
188X Generalized Carcinomatosis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Primary Carcinoma Bladder (Urinary)											3 years
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR-AM Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from JAN 11 1966, to MAY 28 1969, that (I) (we) last saw the deceased alive on MAY 28 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE											22c. DATE SIGNED
Joseph E. Bush M.D.											May 28, 1969
22d. PHYSICIAN'S NAME (Type)											22e. ADDRESS
Joseph E. Bush M.D.											HAMPSTEAD MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			May 31, 1969		Grace Cemetery			Hampstead, Md. Balto. Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tipton - Eline Funeral Home Hampstead, Md.						DATE JUN 3 1969		Charles J. J. J.			



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06422

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06419

1 DECEASED-NAME (Type or Print) ARNOLD First C Middle BALL Last			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 5 3 1969 7:00 AM		2b. HOUR	
3. SEX M	4 RACE W	5 DATE OF BIRTH AUG. 25, 1921	6 AGE (In years last birthday) 47 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN	7. UNDER 24 HRS HOURS 0 MIN	2c. DATE PRONOUNCED DEAD Month May Day 3 Year 1969 8:30 AM
7a. BIRTHPLACE (State or foreign country) Mich.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.
10 CITY OR TOWN OF DEATH CATONSVILLE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 215 Newburg		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLAIMS EXAMINER		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T
13a. USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN CATONSVILLE		13d. STREET AND NUMBER 215 Newburg Ave
14 FATHER'S NAME First GORDON Middle BALL Last			15 MOTHER'S MAIDEN NAME First CATHERINE Middle Mc DONALD Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. 33-416-2364		17. INFORMANT ADDRESS Elizabeth V. Ball 215 Newburg Ave		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Rheumatic Heart Disease (b) 20 years DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE J. Nelson McKay M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 5-3-69		
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-16-69		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		
24. FUNERAL DIRECTOR E. S. Mac Nabb		ADDRESS 301 Frederick Rd Baltimore Md		23d. LOCATION (City or Town) (County) (State) BALTIMORE Md		
25a. REC'D BY REGISTRAR MAY 6 1969		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]				



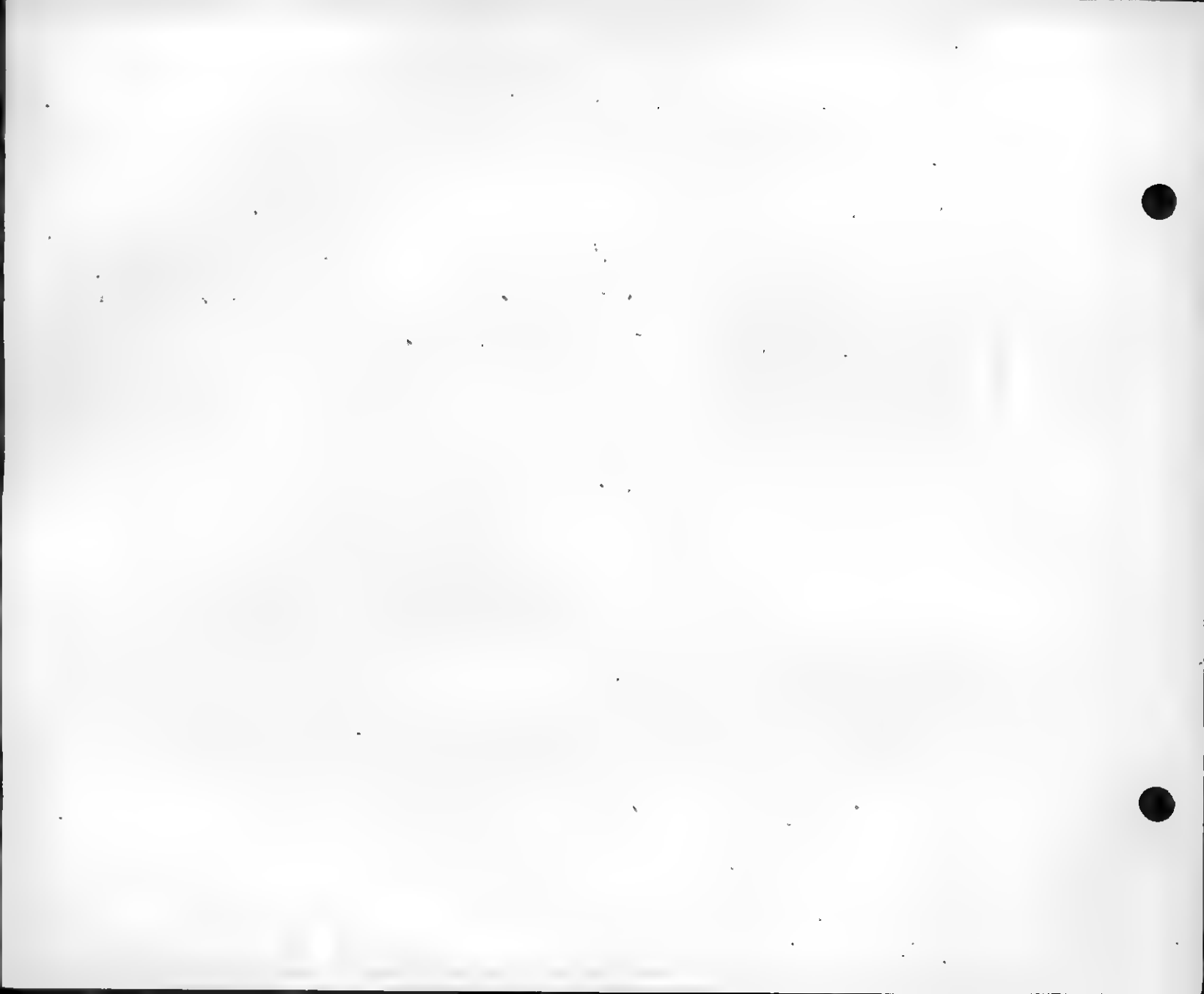
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 48 hours after death.

VR A15 (4)
3044 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
WILLIAM ROLAND BALL								Month Day Year 5 3 1969		4:40 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
MALE		CAUCASIAN		2 MAY, 1984		25 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
DUNDALK		95 KINSHIP RD		FOREMAN		FABRIC PRINTING					
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MD		BALTIMORE		DUNDALK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		95 KINSHIP RD.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
WILLIAM F. BALL								MARY RUSSELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO		212-05-9441		EVELYN B. BALL		SAME					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) H-S-C-V-DISEASE E											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC ARTERIOSCLEROSIS											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
(none)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.									
22a. I certify that (I) (this hospital) attended the deceased from April 8, 1969, to May 2, 1969, that (I) (we) last saw the deceased alive on May 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
MELVIN B. DAVIS M.D.		M.D.						MAY 6, 1969			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
MELVIN B. DAVIS M.D.		6800 HORNINGTON RD DUNDALK MD 21222		BURIAL		MAY 6, 1969		MEADOW RIDGE		DORSEY, MD.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W. Frank Bradley, Dundalk, Md.				MAY 6 1969		[Signature]					

MEDICAL CERTIFICATION



193X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06424

CERTIFICATE OF DEATH

06421

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Conbett</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Conbett</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>Conbett Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Conbett Road</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George G. C. Bange, Jr.</u>				4. DATE OF DEATH Month Day Year <u>May 28, 1969</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1917</u>	
9. AGE (if years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B. & D., Inc. Co.</u>			
13. FATHER'S NAME <u>George G. C. Bange</u>				14. MOTHER'S MAIDEN NAME <u>Martha B. Kruger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>Korean Campaign 212-10-9736</u>			
17. INFORMANT <u>Family records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO (b) <u>Pneumonia with tracheobronchitis</u> DUE TO (c) <u>Ca. thyroid</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>2/23, 1969</u> to <u>5/27, 1969</u> , that (I) (we) last saw the deceased alive on <u>5/27, 1969</u> , and that death occurred at <u>6:30 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R. G. Chambers</u>				22b. DATE SIGNED <u>5/28/69</u>			
22c. PHYSICIAN'S NAME (Type) <u>R. G. Chambers</u>				22d. ADDRESS <u>538 Park Ave. Bldg. 2/20/</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 31, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sunnybrook, Balto. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 4 1969</u>			
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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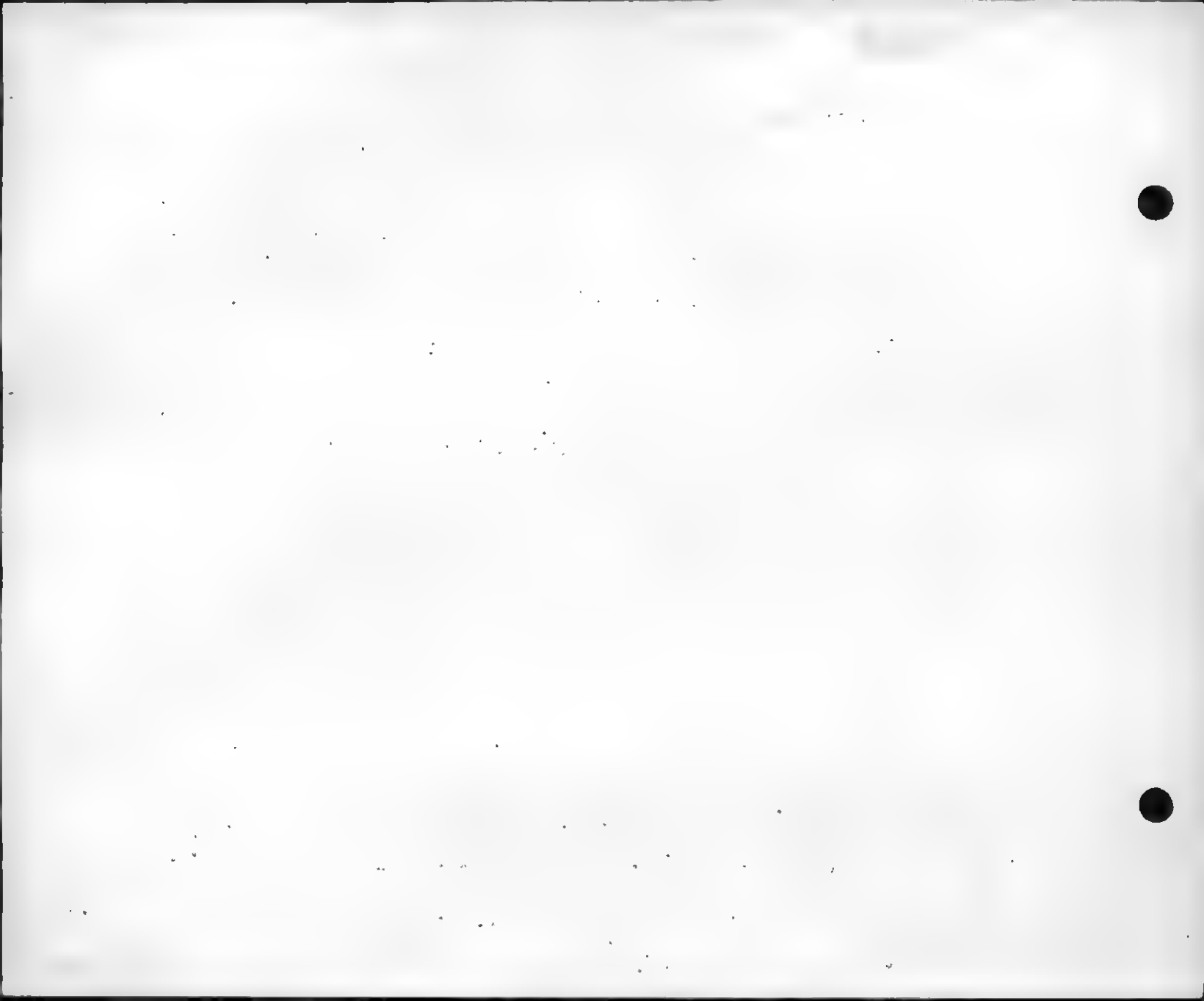
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06425										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06422																													
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
SARA DOCKRIDE BERNARD BANKS										MAY 8th 1969										7:40 AM																													
3 SEX F										4 RACE W										5. DATE OF BIRTH JULY 11, 1881										6. AGE (in years last birthday) 87 YRS.																			
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH BALTIMORE Co. Md.																			
10. CITY OR TOWN OF DEATH TOWSON, MD										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 615 CHESTNUT AVE										12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) SECRETARY										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.										13b. COUNTY BALTIMORE										13c. CITY OR TOWN TOWSON										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 615 CHESTNUT AVE									
14. FATHER'S NAME First MIDDLE Last GEORGE W. BANKS										15. MOTHER'S MAIDEN NAME First MIDDLE Last SALLIE H. TODD										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO										16b. SOCIAL SECURITY NO. 220-30-0073A										17. INFORMANT U. Litch R. N. Address 615 CHESTNUT AVE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma Bowel & Liver DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 mos																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 11										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 3.4. 1954, to May 8, 1969, that (I) (we) last saw the deceased alive on May 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE Newland Edward Day M.D.										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED May 8, 1969																													
22d. PHYSICIAN'S NAME (Type) NEWLAND EDWARD DAY MD										22e. ADDRESS 4-E-33rd St Balto Md.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 5-10-69										23c. NAME OF CEMETERY OR CREMATORY LONDON PARK CEMETERY										23d. LOCATION (City or Town) (County) (State) BALTIMORE Md.																			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.										ADDRESS 1050 YORK RD. Towson, Md 21204										25a. REC'D BY REGISTRAR DATE MAY 9 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																			

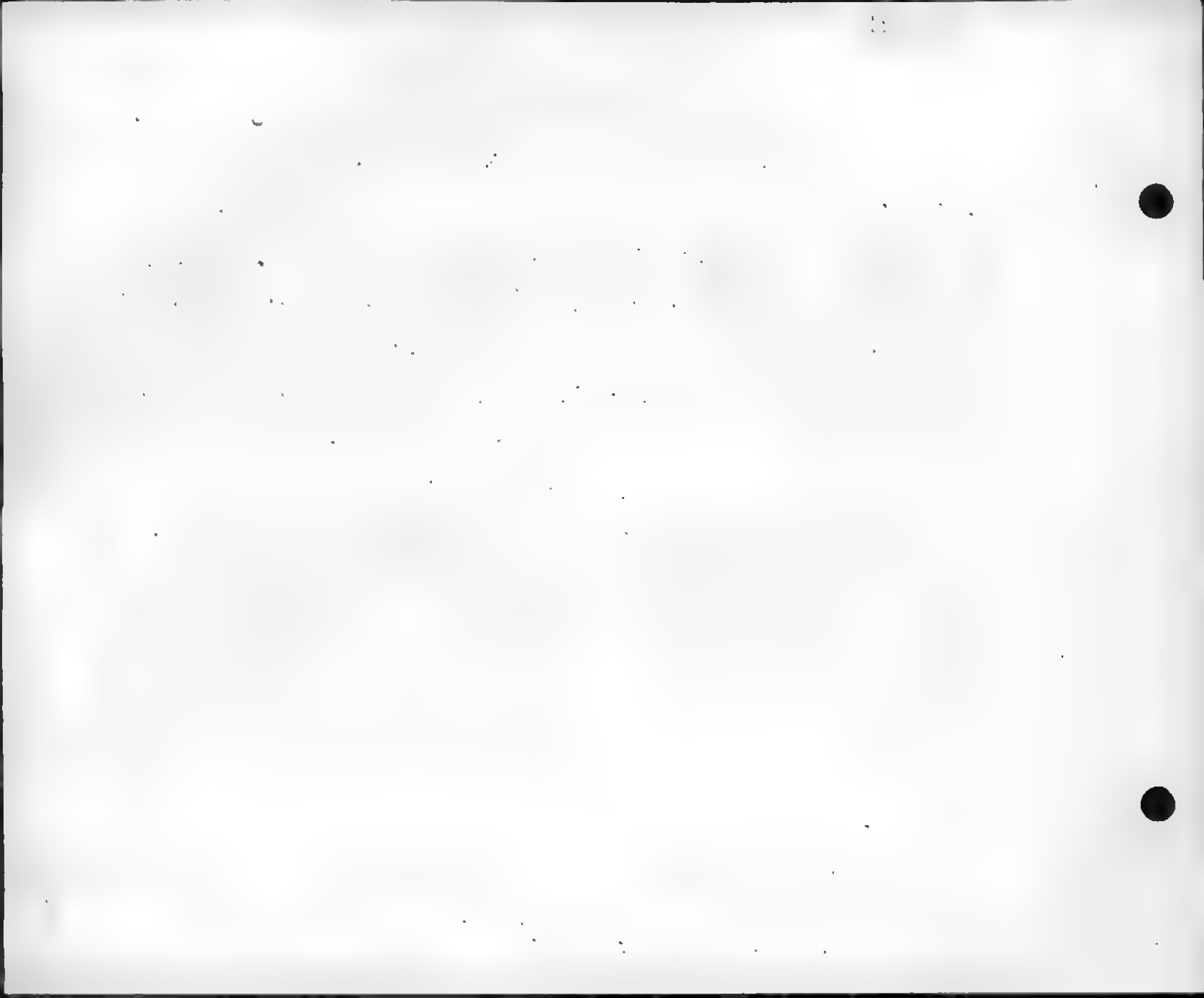


Page 4 may be retained by the hospital or attending physician.

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1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		Month		Day		Year		2b HOUR	
PRUDENCE SMITH		BATES						5		5		5		1969		02:30 P	
3 SEX		4 RACE		5 DATE OF BIRTH		1885		6 AGE (In years last birthday)		83		YRS		MONTHS		DAYS	
FEMALE		CAUCASIAN		10-23-1886													
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH											
VIENNA.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE											
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY											
DUNDALK		7303 SHIPWAY		HOUSEWIFE													
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER									
MD.		BALTIMORE		DUNDALK				7303 SHIPWAY									
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last			
JAMES						SMITH		RACHEL						FISHER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address											
NO		213-01-07188		WILLIAM BATES HUSBAND - SAME													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
		Acute myocardial infarction		Equivocal old infarction lateral													
		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c) Arteriosclerotic cardio-vascular disease															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
		19															
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that (I) (this hospital) attended the deceased from 2/26, 1969, to 5/6, 1969, that (I) (we) last saw the deceased alive on 5/5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED											
B. N. Lazard M.D.																	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS															
BENIGNO R. LAZARO		59 DUNDALK AVE. - 21222															
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)											
BURIAL		8 MAY, 1969		OAK LAWN		BALTIMORE CO. Md.											
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE													
Walter Rinko Bradley, Dundalk, Md.		MAY 7 1969		R. L. Lazard													

VR A15M
30M REV 1.6

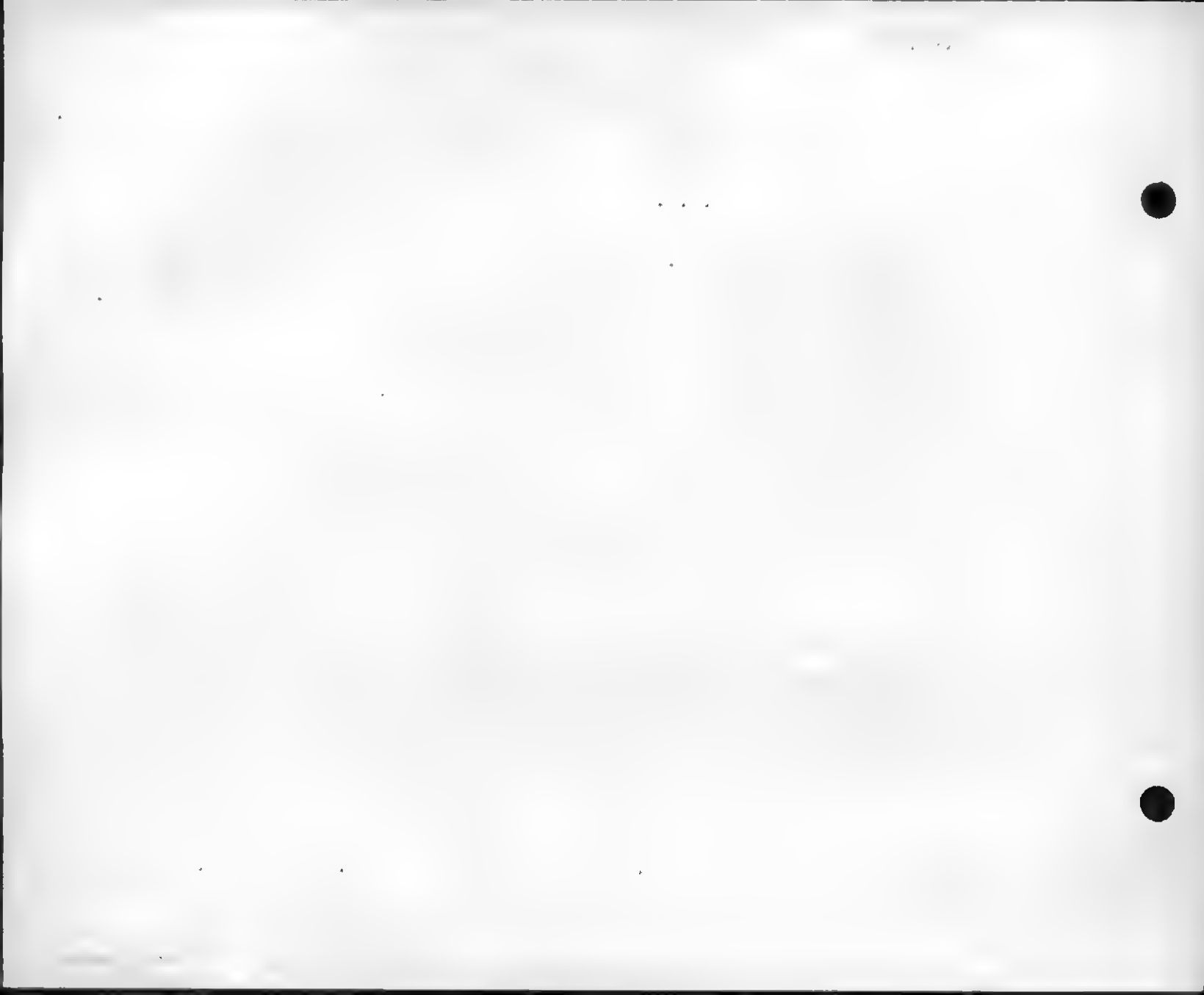


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VR A15
45M 1

06427												06425																			
1 DECEASED NAME (Type or print)												2a. DATE OF DEATH																			
First				Middle				Last				Month				Day				Year				2b. HOUR							
WELZIE				MONROE				BEAR				May				30				1969				4.05 PM							
3 SEX				4 RACE				5 DATE OF BIRTH				6 AGE (In years lost birthday)				7 UNDER 1 YEAR				8 UNDER 24 HRS											
Male				White				8-17-70				98 YRS.				MONTHS				DAYS				HOURS				MIN			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH																			
Maryland				U.S.A.								Baltimore												Md							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY																			
Towson				St. Joseph Hospital				Rail Road Cond.				Rail Road																			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER															
Maryland				Baltimore				Parkville				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				8706 Lackawanna Ave.-21234															
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME																											
First				Middle				Last				First				Middle				Last											
Christian				Bear								Hanna Marie Plain																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO				17 INFORMANT				Address																			
No				218-14-9446				Mr. Charles V. Bear, Same as # 13																							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema																															
41-7 DUE TO, OR AS A CONSEQUENCE OF acute myocardial infarction																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																															
DUE TO, OR AS A CONSEQUENCE OF (b)																															
DUE TO, OR AS A CONSEQUENCE OF (c)																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																															
Infarct of small intestine secondary to aortic atherosclerotic aneurysm																															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from 5-29-1969, to 5-30-1969, that (I)-(we) last saw the deceased alive on 5-30-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																															
22b. SIGNATURE Samuel H. Cook, M.D.												22c. DATE SIGNED May 31, 1969																			
22d. PHYSICIAN'S NAME (Type) Samuel H. Cook, M.D.												22e. ADDRESS 7620 York Rd., Towson Md., 21204																			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)																			
Burial				June 2, 1969				Druid Ridge Cemetery				Pikesville, Maryland																			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204												25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge																			
DATE JUN 3 1969																															



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VR A15
30M REV 7-66

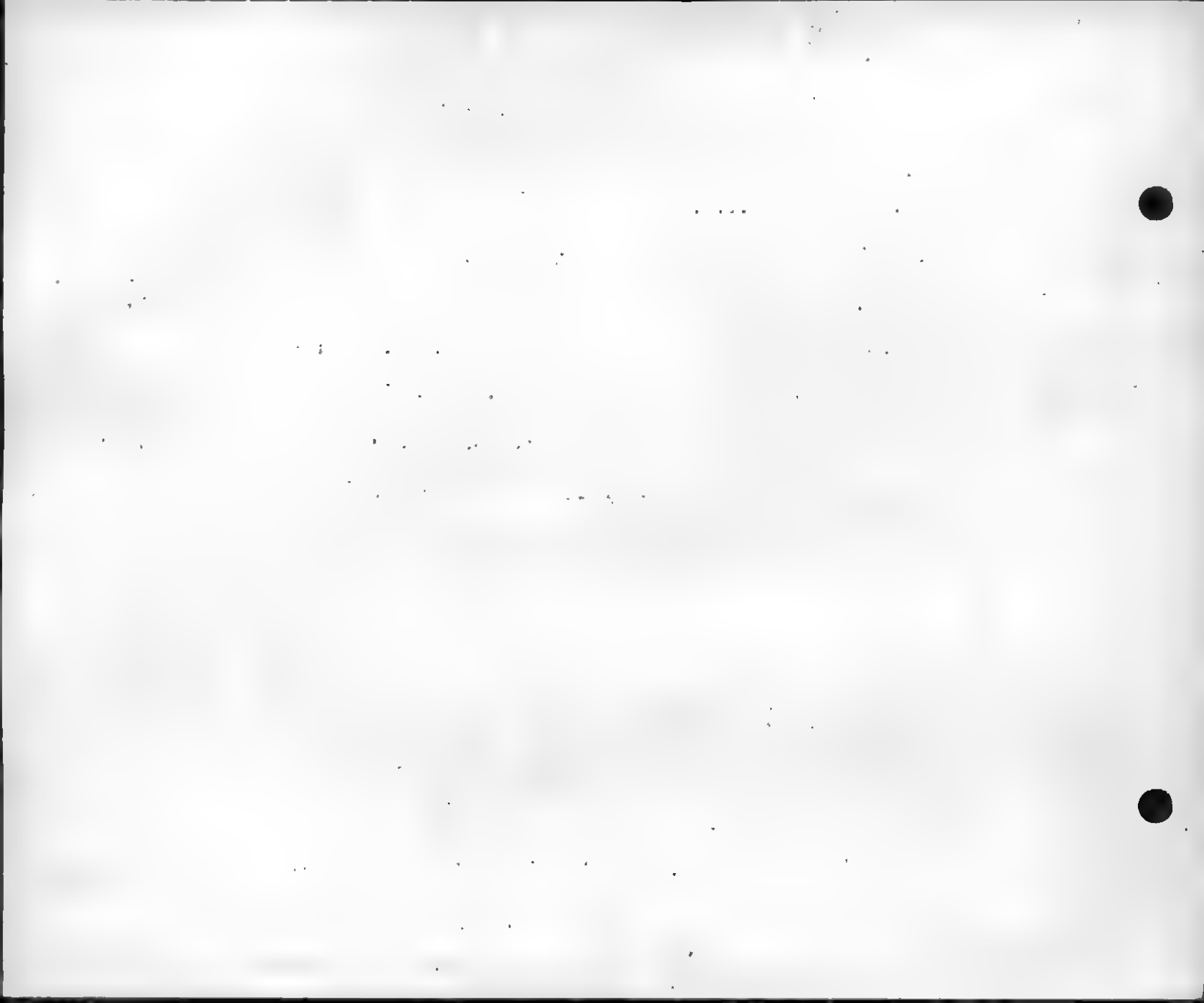
06428

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06426

1 DECEASED-NAME (Type or print)		First ANNA	Middle	Last BELL	2a. DATE OF DEATH Month 5 Day 13 Year 69			2b. HOUR 1:30 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH 6/13/88		6 AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shady Nook Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Upland Apts. 4608 LawnPark Rd	
14 FATHER'S NAME First Lernon Beall Middle Last				15 MOTHER'S MAIDEN NAME First Ann R. Anderson Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT Address 15243 Mr. Bell, 420 Parkview Drive, Pittsburgh/Pa					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction 460x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Pharyngitis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 2 weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ax-									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/23/68 , to 5/13/69 , that (I) (we) last saw the deceased alive on 3/11/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Cliff Ratliff DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 5/13/69					
22d. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, M.D.				22e. ADDRESS 4605 Edmondson Ave					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/16/69		23c. NAME OF CEMETERY OR CREMATORY Trinity Meth. Church Cem		23d. LOCATION (City or Town) (County) (State) Odenton, Maryland			
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229				25a. REC'D BY REGISTRAR DATE MAY 15 1969		25b. REGISTRAR'S SIGNATURE James Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

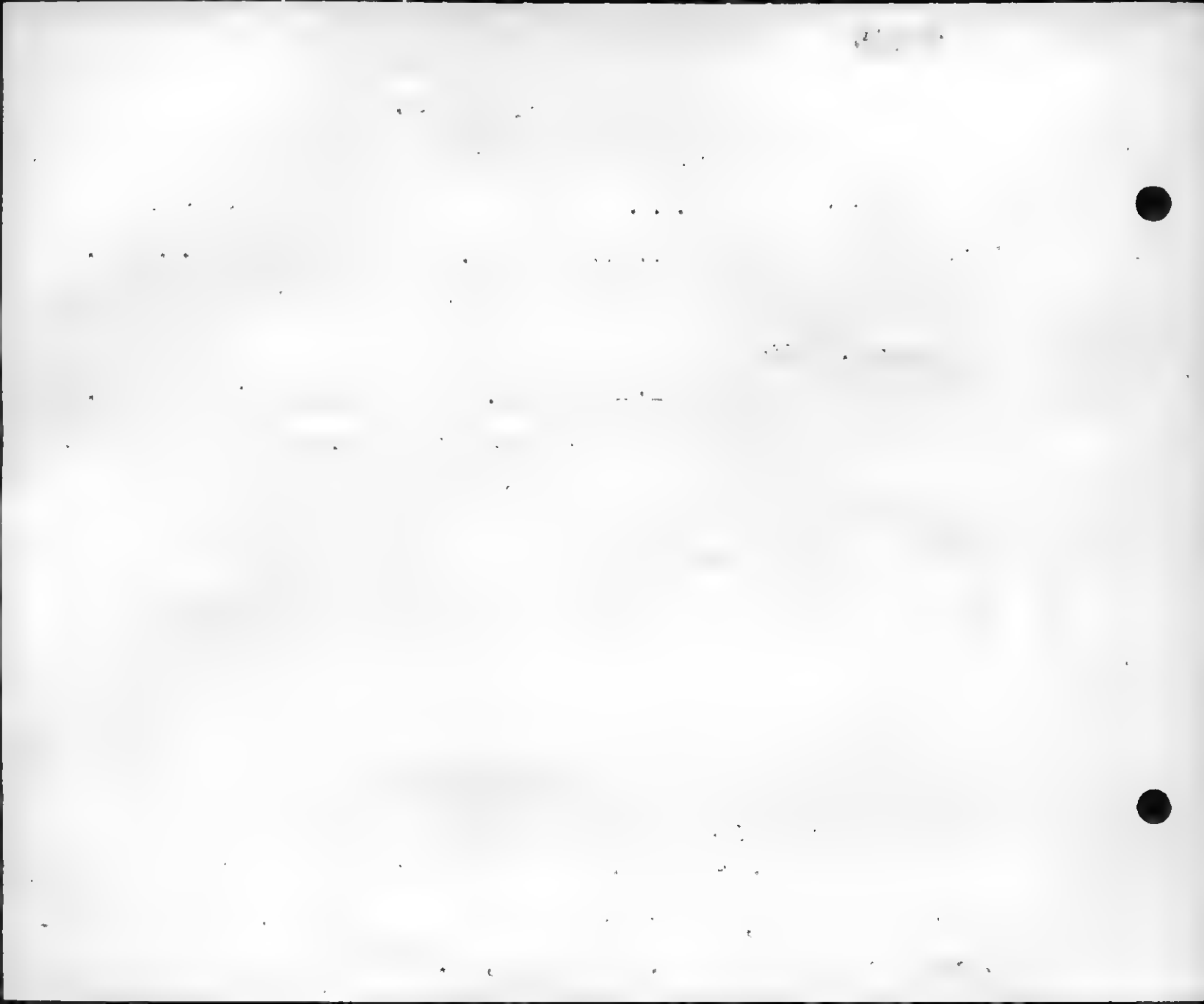
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06429

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06427

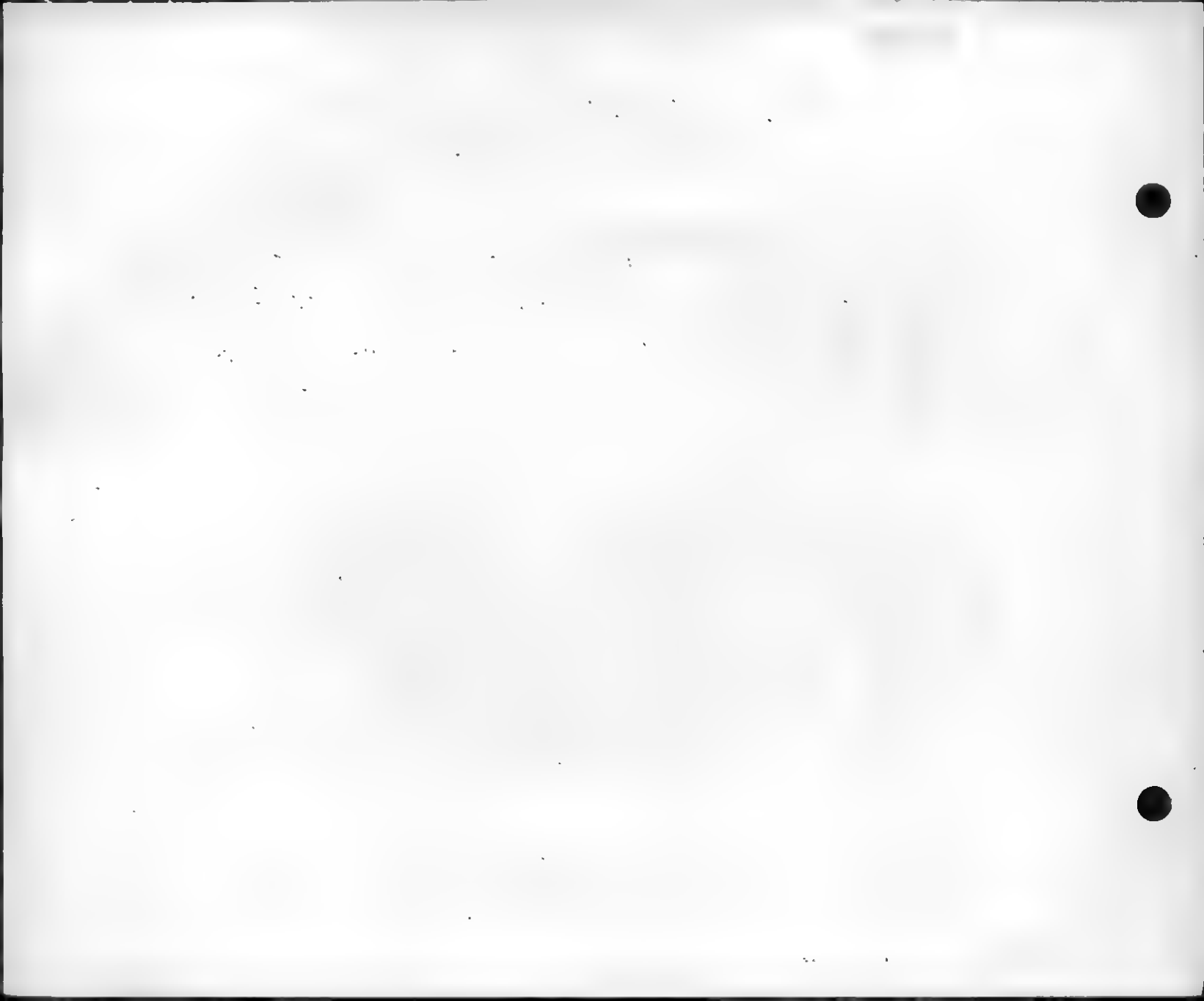
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	2b. HOUR	
Ferdinand		E.	Bellin	Sr.	May	Month 27 Day 1969	9:25 AM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	
Male	White		2/7/06 1906		63 YRS.	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Baltimore	U.S.A.				Baltimore County Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work on life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown		Balto. Co. Gen. Hosp.		Engineer		U.S. Govt.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY 1/4 IN TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Baltimore		Randallstown		Box 299 D, Liberty Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Edward A. Bellin		Amelia Metz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
NO		218-30-5674		Mrs. Thelma Bellin Box 299 Liberty Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A S H D - Arrhythmia fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH App. 3 weeks
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5/3, 1969, to 5/21, 1969, that (I) (we) last saw the deceased alive on 5/21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED					
Howard E. Hall		May 28, 1969					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Howard E. Hall, M. D.		Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		May 31, 69		Parkwood Cemetery		Parkville Maryland Balto Co	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Loring Byers		8728 Liberty Rd. Randallstown, Md.		MAY 29 1969		H. Douglas Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
WALTER S. BELLIS JR.						5 Month 4 Day 69 Year		M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years ast birthday)		7 UNDER 1 YEAR		
M		W		6/27/07		61 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Md		U.S.				BALTO.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CATONSVILLE			23 BLOOMSBURG			BTO. PR				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md			BALTO		CATONSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		23 BLOOMSBURG	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
WALTER S. BELLIS			GERTRUDE HARKINS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
NO					CATHERINE BELLIS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Chronic Nephritis									5 years	
DUE TO, OR AS A CONSEQUENCE OF (b) Glomerulonephritis									5 years	
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES Mellitus									17 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Arteriosclerotic Heart Disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 4/10, 1967, to 5/4, 1969, that (I) (we) last saw the deceased alive on 5/1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Max J. Miller								22c. DATE SIGNED 5/5/69		
22d. PHYSICIAN'S NAME (Type) MAX J MILLER MD.								22e. ADDRESS 1047 Ingleside Ave 21228		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		5/6/69		GOOD SHEPHERD		HOW. CO. Md				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
E.S. MALNAB 21228				MAY 7 1969		[Signature]				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

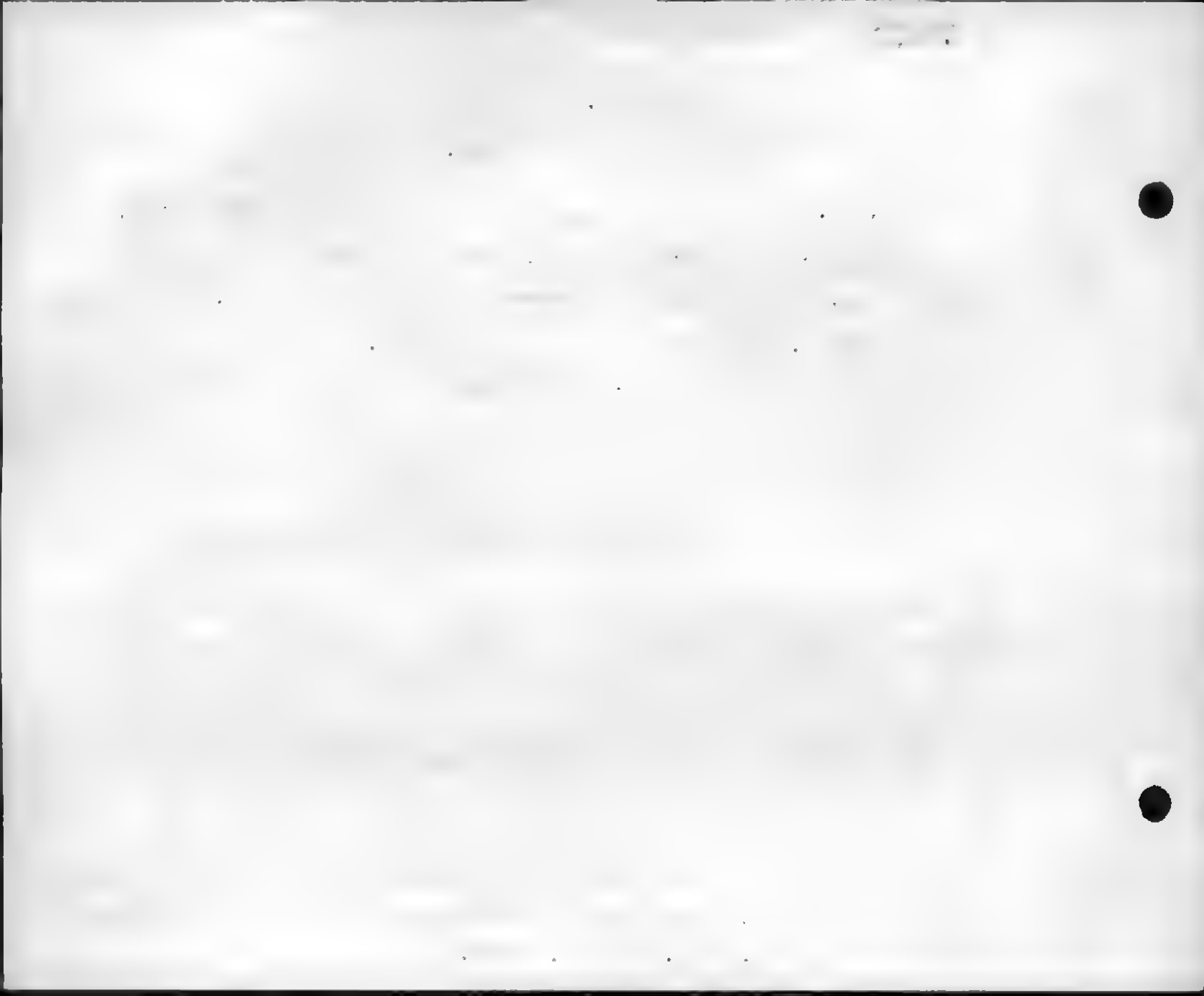
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06431

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06429

1. DECEASED-NAME (Type or print) LILLIE (LILLY) B. BENNETT			2a. DATE OF DEATH Month 5 Day 14 Year 69			2b. HOUR 10:20 M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH Sept. 27, 1874		6. AGE (In years last birthday) 94 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Balto, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Paradise Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. CITY OR TOWN City of Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2010 St. Paul Street			
14. FATHER'S NAME First Middle Last GOFARTH R. BENNETT				15. MOTHER'S M maiden name First Middle Last LILLY C. (BURNS)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO 220-54-2906T		17. INFORMANT Address various records (No living relatives)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Disease (b) Hypertensive Cardio-vascular DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (the hospital) attended the deceased from 4/1 , 19 69 , to 5/14 , 19 69 , that (I) (we) last saw the deceased alive on 5/14 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Domingo M.D. DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/14/69			
22d. PHYSICIAN'S NAME (Type) DOMINGO C. SORONGON M.D.				22e. ADDRESS 3915 HOLLINS FERRY RD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE May 16, 1969		23c. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av., Balto. 1				25a. REC'D BY REGISTRAR MAY 19 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

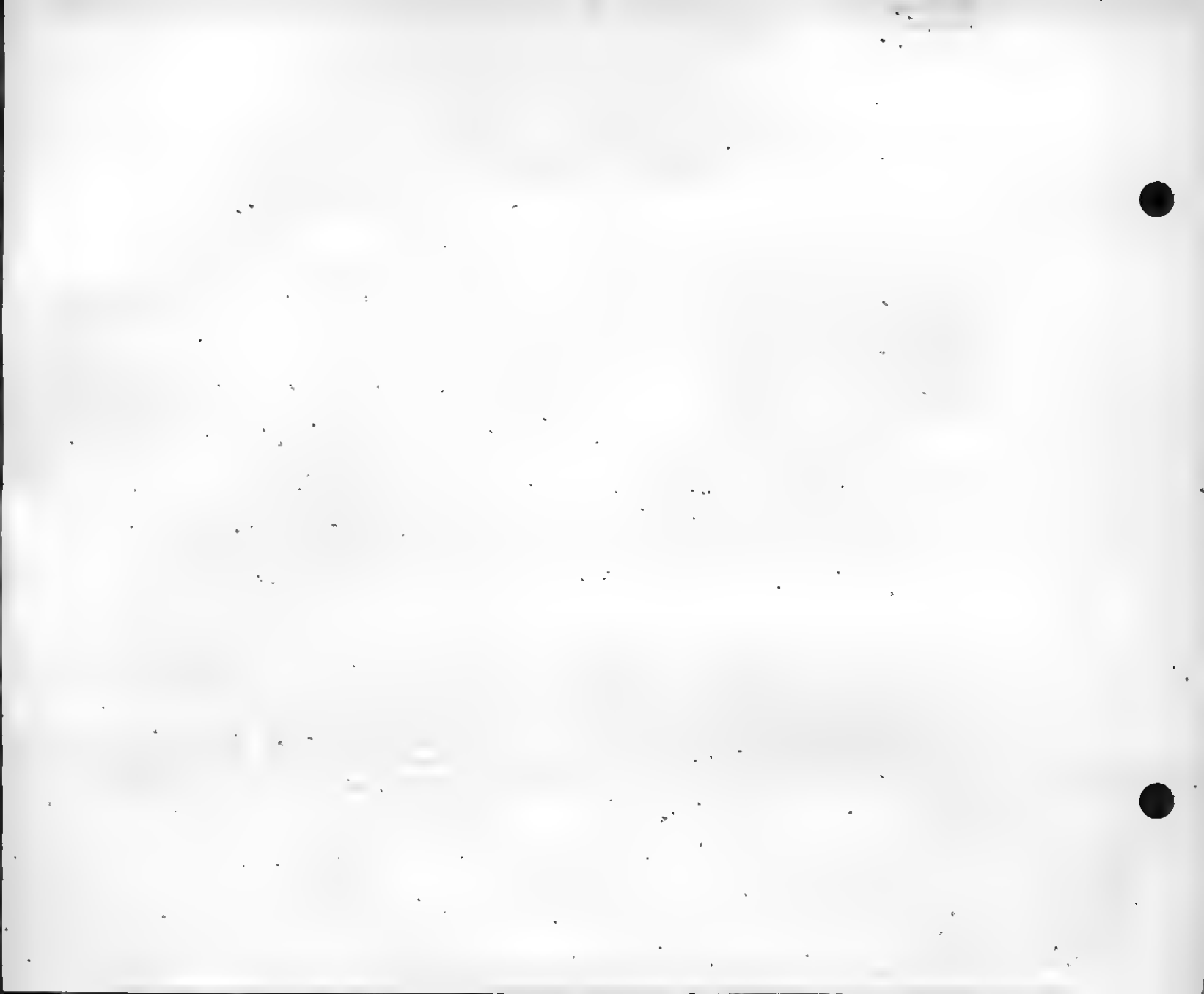


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4160

06432		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06430	
Item 13 Film G413 5/29/69 kk					
1. DECEASED NAME (Type or print) <i>MARY E BERGMAN</i>			2a. DATE OF DEATH 5 Month 15 Day 69 Year		2b. HOUR 1:35 PM
3 SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH		6 AGE (In years lost birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i> Md.		
10. CITY OR TOWN OF DEATH <i>LOWSON</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>CHESAPEAKE MANOR NURSING HOME 5700 E. JOPPA RD</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>3615-1st AVE. 21234</i>
14. FATHER'S NAME First Middle Last <i>SEBASTIAN THOMAS</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>CATHERINE RUDOLPH</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>K. PESSAGNO BOX 145 RT. 2 BALTO. 21012</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Hypertensive Cardiac Disease</i> (c) <i>Hypertensive Encephalopathy</i> (d) <i>Arteriosclerosis of the Kidneys</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>15 years</i> <i>8 weeks</i> <i>2 years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Congestive Heart Failure with peripheral Edema</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 1954</i> to <i>May 15 1969</i> , that (I) (we) last saw the deceased alive on <i>May 15 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John H. Hirschfeld MD</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/15/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>JOHN H. HIRSCHFELD MD</i>		22e. ADDRESS <i>6919 Harford Rd Baltimore 21234</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/19/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem. Balt. 150, ave.</i>	
23d. LOCATION (City or Town) (County) (State) <i>Baltimore</i>					
24. FUNERAL DIRECTOR <i>B. DARGOWSKI</i>		ADDRESS <i>214 E. BALTIMORE ST.</i>		25a. REC'D BY REGISTRAR <i>MAY 20 1969</i>	
25b. REGISTRAR'S SIGNATURE <i>Judge</i>					



4/22

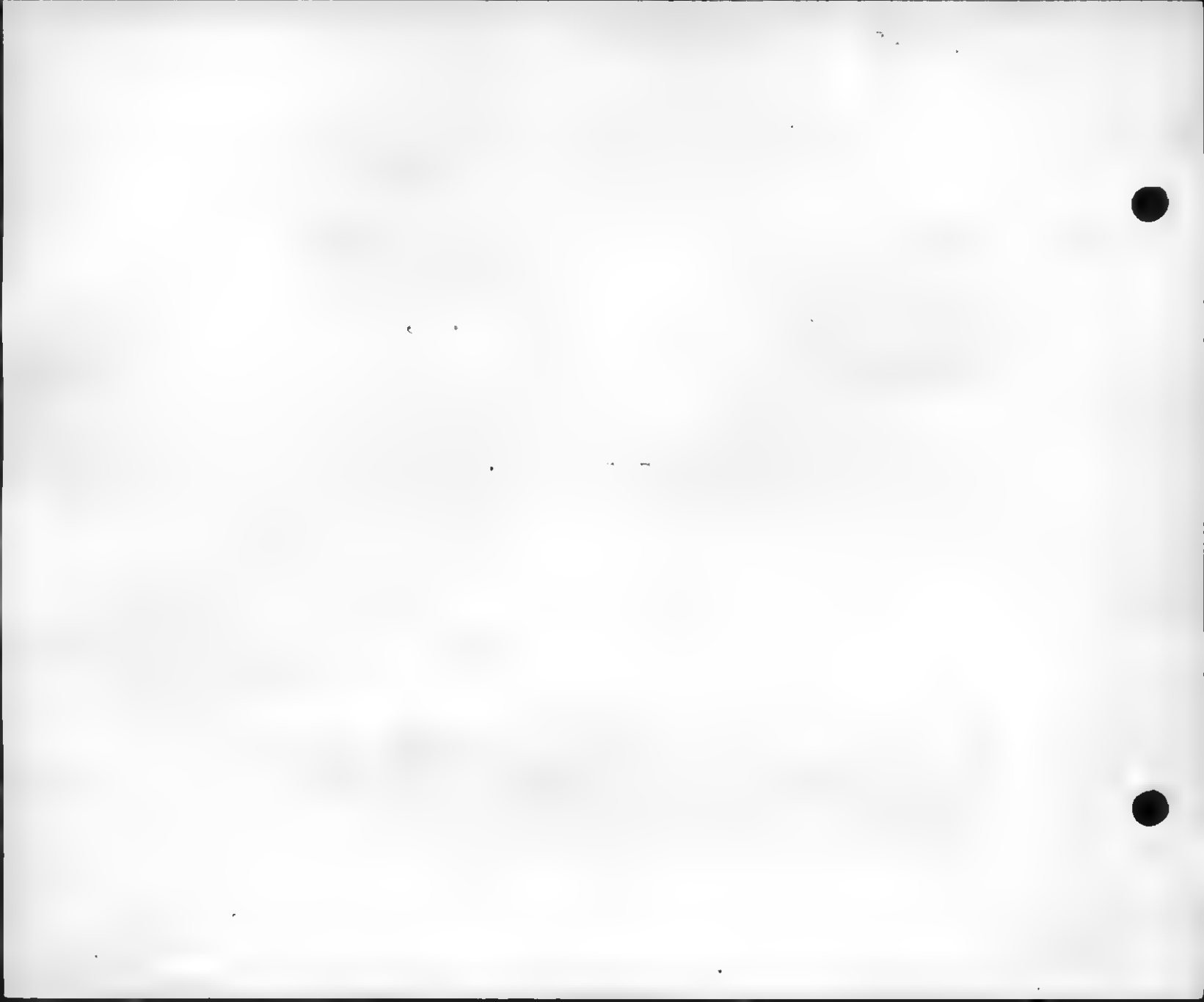
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25M 1/67

CBP

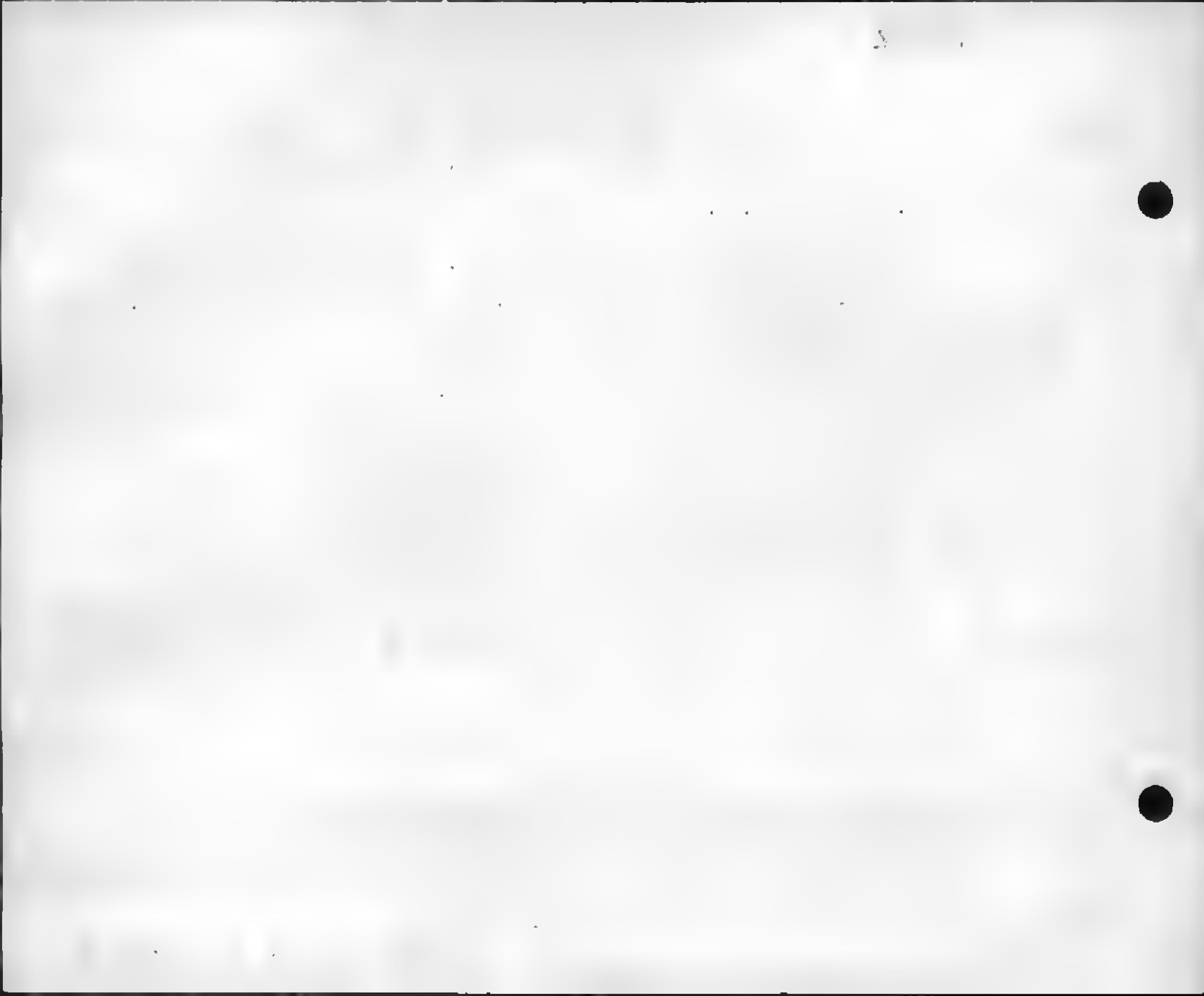
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06433					06431				
CERTIFICATE OF DEATH									
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>---</u>				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix Maryland</u>				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chesapeake Manor Nursing Home</u>					d. STREET ADDRESS <u>373 Blenheim Road</u>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Bertazon</u> Last <u>Bertazon</u>					4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1969</u>				
5. SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 27, 1890</u>		9 AGE (In years lost birthday) <u>78</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Italy</u>			12 CITIZEN OF WHAT COUNTRY? <u>Italy</u>		
13. FATHER'S NAME <u>?</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16 SOCIAL SECURITY NO <u>215-22-1723</u>		17 INFORMANT <u>Mrs. Julia Isernock</u>			Address <u>373 Blenheim Road</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized Arteriosclerotic</u> DUE TO <u>Cardio Renal Vascular Disease</u> (c) <u>20 yrs</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5/26</u> , 19 <u>69</u> , to <u>5/29</u> , 19 <u>69</u> , that (I) <u>did</u> last saw the deceased alive on <u>28 May 1969</u> , and that death occurred at <u>4:10 PM</u> , from causes and on the date stated above.									
22a SIGNATURE <u>Charles F. O'Donnell</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>					22d ADDRESS <u>7501 York Rd Baltimore, Maryland</u>				
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/2/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>			23d LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>		
24. FUNERAL DIRECTOR <u>Leonard J Ruck Inc. Baltimore, Maryland</u>					25a REC'D BY REGISTRAR <u>DAI JUN 2 1969</u>		25b REGISTRAR'S SIGNATURE <u>William J. Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>7</div> <div>1</div> <div>06434</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06432</div>																		
1 DECEASED-NAME (Type or print) FLORENCE			First Rebecca			Middle BICKING			Last			2a. DATE OF DEATH Month 5 Day 26 Year 1969			2b. HOUR 7 P. M.			
3 SEX female			4 RACE white			5 DATE OF BIRTH Feb. 19, 1893			6 AGE (In years last birthday) 76 YRS			IF UNDER 1 YEAR MONTHS DAYS 			IF UNDER 24 HRS HOURS MIN 			
7a BIRTHPLACE (State or foreign country) Md.			7b CITIZEN OF WHAT COUNTRY? U. S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore Md									
1d CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SPRING GROVE STATE HOSP.			2a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter			12b KIND OF BUSINESS OR INDUSTRY B. F. Co.									
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.			13b COUNTY 			13c CITY OR TOWN Balto.			13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e STREET AND NUMBER 1117 Carroll St.						
14. FATHER'S NAME First William Morris			Middle BICKING			Last			15 MOTHER'S MAIDEN NAME First Catherine			Middle KENNEDY			Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO 214-01-0208A			17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL												
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis															1 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																		
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis															years			
DUE TO, OR AS A CONSEQUENCE OF (c) 																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Nephrosclerosis - Uremia																		
19a DATE OF OPERATION 4/3/69			19b CONDITION FOR WHICH OPERATION WAS PERFORMED 			20a AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)												
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 			21f LOCATION Street or R.F.D. No 			City or Town 			County 			State 			
22a. I certify that (X) (this hospital) attended the deceased from May 14 , 19 69 , to May 26 , 19 69 , that (I) (we) last saw the deceased alive on May 26 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b SIGNATURE A. Gutierrez			DEGREE 			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c DATE SIGNED 5-26-69									
22d PHYSICIAN'S NAME (Type) ALBERTO M. GUTIERREZ, MD			22e ADDRESS SPRING GROVE STATE HOSPITAL															
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 5/30/69			23c NAME OF CEMETERY OR CREMATORY New Cathedral Cem.			23d LOCATION (City or Town) Baltimore			(County) Ind.			(State) Ind.			
24 FUNERAL DIRECTOR John Brown - Inc.			ADDRESS Inc. Inc 901 N. Main St.			25a REC'D BY REGISTRAR MAY 28 1969			25b REGISTRAR'S SIGNATURE John Brown									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06435

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06433

1. DECEASED-NAME (Type or print) EDWARD			First Middle Last			2a. DATE OF DEATH Month Day Year MAY 29, 1969			2b. HOUR A M 5:15		
3 SEX MALE			4. RACE CAUCASIAN			5. DATE OF BIRTH 2/28/06			6. AGE (In years last birthday) 63 YRS		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE		
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOSPITAL VETERANS ADMINISTRATION			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BAKERS HELPER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 146 NORTH CURLEY STREET		
14. FATHER'S NAME First Middle Last JIM WENZEL			15. MOTHER'S MAIDEN NAME First Middle Last ELEANOR								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown YES WW II			16b. SOCIAL SECURITY NO 215 14 4715			17. INFORMANT Address CLINICAL RECORDS, VA HOSP, FT HOWARD, MD					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BACTEREMIA 315X DUE TO, OR AS A CONSEQUENCE OF (b) HYPERSENSITIVITY REACTION TO DRUG DUE TO, OR AS A CONSEQUENCE OF (c) ABSCESS RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) CIRRHOSIS OF LIVER											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES NONE		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/24/69 , 19__, to 5/29/69 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/29/69 , 19__, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death.											
22b. SIGNATURE J. D. Talbert, M.D.						DEGREE M.D.			22c. DATE SIGNED 5/29/69		
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.						22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 6/2/69			23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR JOSEPH N. ZANNINO						ADDRESS 257 S. Conkling St. Balto. Md.			25c. REC'D BY REGISTRAR 2 1969		
						25b. REGISTRAR'S SIGNATURE Charles Judge					

VR A 45H



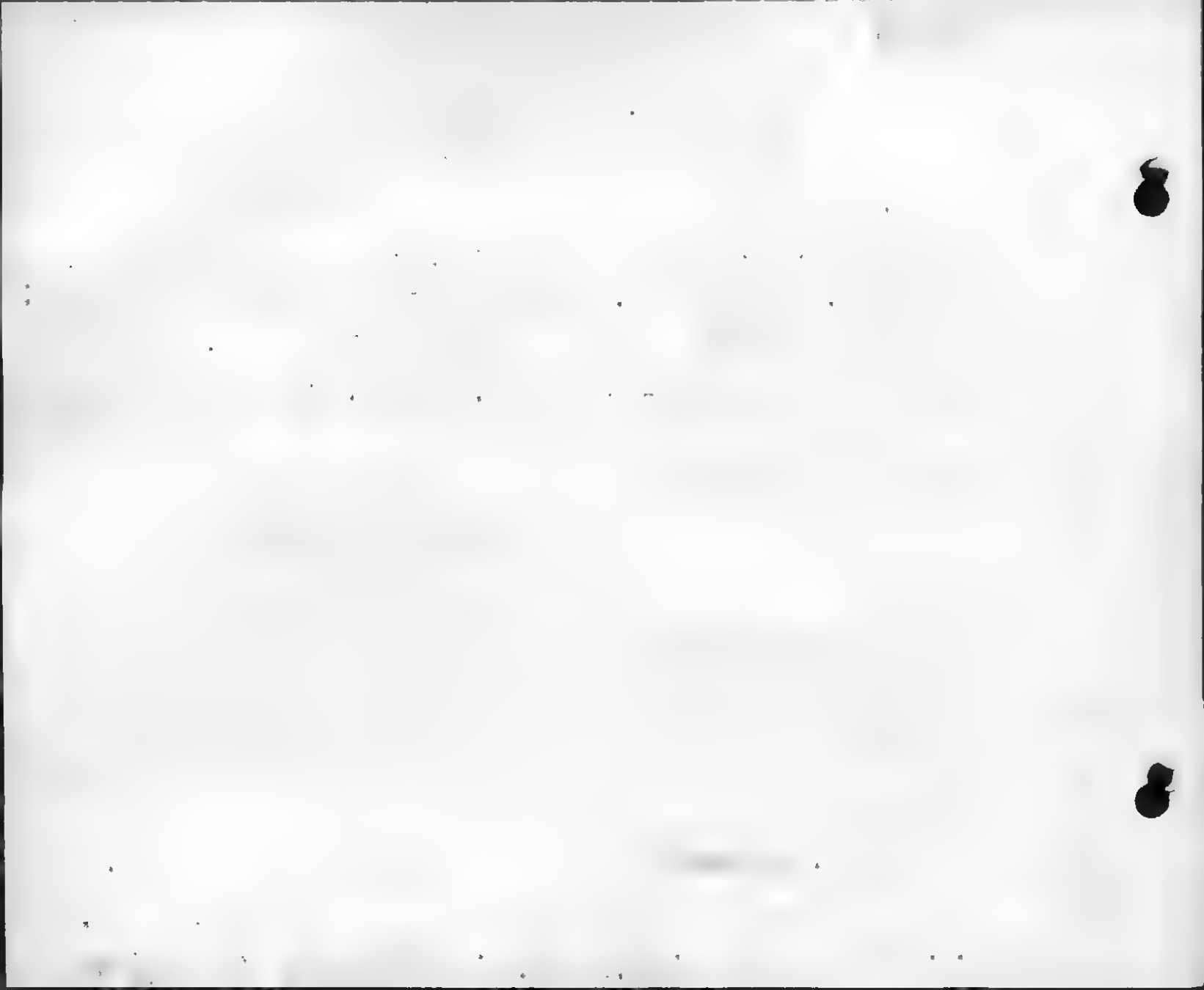
491

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or print)			First Elmer			Middle H.			Last Bing			2a. DATE OF DEATH 5 Month 23 Day 69 Year			2b. HOUR 1:55 AM		
3. SEX M			4. RACE W			5. DATE OF BIRTH 7-19-04			6. AGE (In years last birthday) 64 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
7a BIRTHPLACE (State or foreign country) Md.			7b CITIZEN OF WHAT COUNTRY? U S A			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore								
10 CITY OR TOWN OF DEATH Towson, Balto. Co.			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8151 Loch Raven Blvd.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dispatcher - Curtis Bay Towing Co.			12b KIND OF BUSINESS OR INDUSTRY								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Balto.			13c CITY OR TOWN Towson			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 8151 Loch Raven Blvd.					
14 FATHER'S NAME First John			Middle Henry			Last Bing			15 MOTHER'S MAIDEN NAME First Lulu			Middle M.			Last Hill		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b SOCIAL SECURITY NO 215-09-0080			17 INFORMANT Mrs. Velma M. Bing			Address (Same)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Bronchitis & Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bronchitis & Emphysema DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Bronchitis & Emphysema												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Dec 11 , 19 66 , to May 22 , 19 69 , that (I) (we) last saw the deceased alive on May 22 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Dr. Anselmo Allegro			DEGREE Dr.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 5/23/69								
22d. PHYSICIAN'S NAME (Type) Dr. Anselmo Allegro			22e. ADDRESS 8155 Loch Raven Blvd.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/26/69			23c. NAME OF CEMETERY OR CREMATORY Loudon Park			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.								
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			ADDRESS 4905 York Rd. Balto. 12, Md.			25a. REC'D BY REGISTRAR MAY 26 1969			25b. REGISTRAR'S SIGNATURE J. Charles Judge								



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06437

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

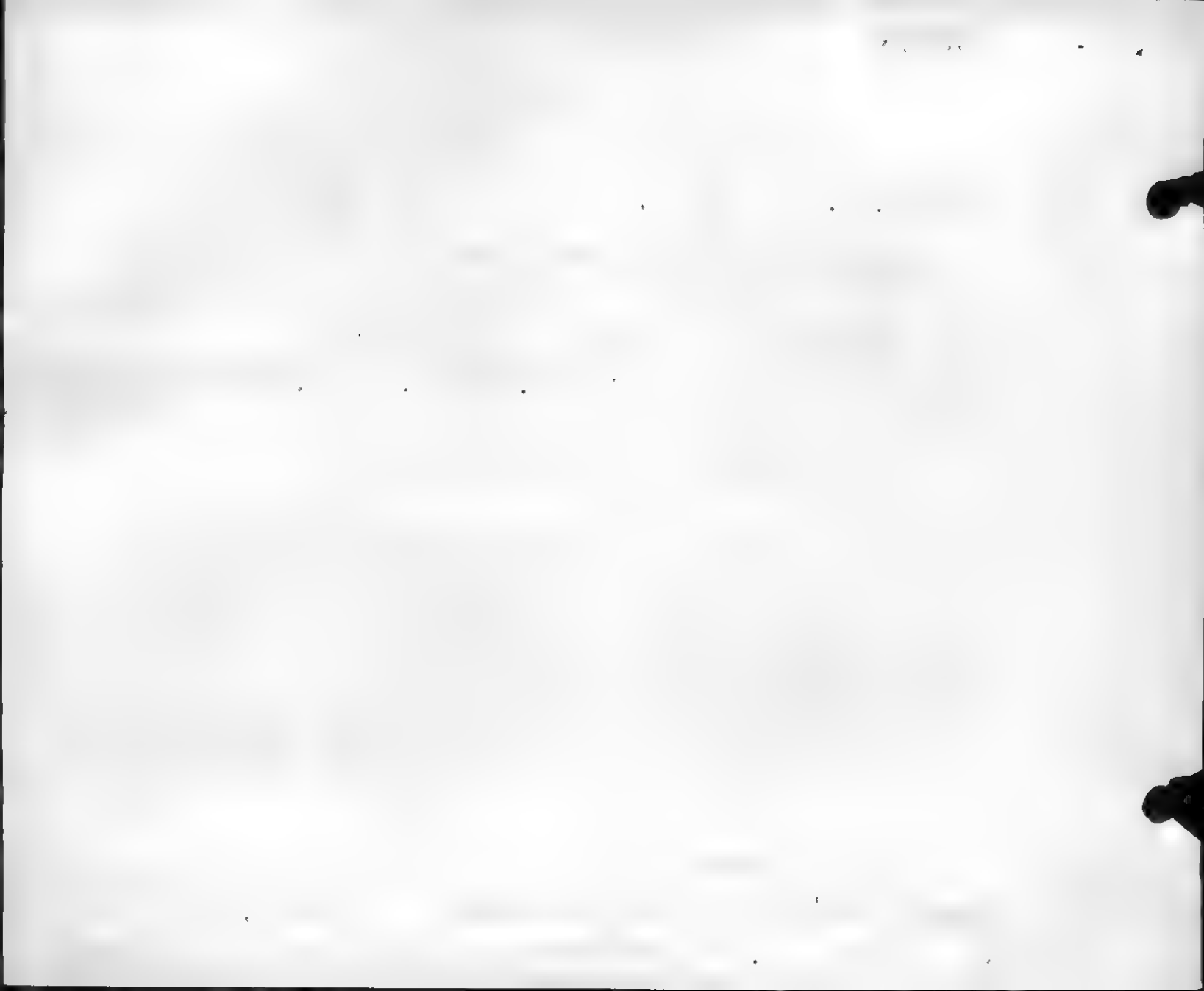
06435

AM

1. DECEASED NAME (Type or Print) First Middle Last Merrill T. Bittner			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year ESTI MATED <input type="checkbox"/> 5, 10 1969		2b. HOUR 10:45
3 SEX Male	4. RACE White	5. DATE OF BIRTH 7/5/32	6. AGE (in years last birthday) 36 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Laborer
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3509 Keswick Rd. Zone 21211
14. FATHER'S NAME First Middle Last ?			15. MOTHER'S MAIDEN NAME First Middle Last ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO (If yes give year or dates of service) 216-28-1690		17. INFORMANT ADDRESS Lois Bittner 3905 Keswick Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease. 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town or county)		22b. DATE SIGNED May 11, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/13/69	23c. NAME OF CEMETERY OR CREMATORY Jessups		23d. LOCATION (City or Town) (County) (State) Balto. Co.
24. FUNERAL DIRECTOR Paul E. Chenoweth Jr. 3617 Chenoweth Ave.			25a. REC'D BY REGISTRAR MAY 13 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 4, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 120, 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06433		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		06436	
1 DECEASED NAME (Type or print) <i>Max</i>		First <i>S.</i> Middle <i>Black</i>		2a. DATE OF DEATH <i>5</i> Month <i>25</i> Day <i>69</i> Year		2b. HOUR <i>11:45</i> AM	
3 SEX <i>Male</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH <i>8/20/82</i>		6 AGE (In years last birthday) <i>86</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md.	
10. CITY OR TOWN OF DEATH <i>Towson, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Chesapeake Manor Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>TAX</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>SERVICE</i>	
13a. USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <i>MEDEL</i> Middle <i>SCHWARTZ</i> Last <i>PAULINE</i>		15. MOTHER'S MARDEN NAME First <i>PAULINE</i> Middle <i>?</i> Last <i>?</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>109-12-7276</i>		17. INFORMANT Address <i>MR. JOSEPH A. WALDMAN, 3214 WOODVALLEY DRIVE</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1952</i> , to <i>5-22, 1969</i> , that (I) (we) last saw the deceased alive on <i>5-25, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Jerome Collier</i>		DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>5-25-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>JEROME COLLIER</i>		22e. ADDRESS <i>2217 South Rd</i>					
23a. BURIAL, CREMATION, REMOVAL, (Specify) <i>BURIAL</i>		23b. DATE <i>5-27-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LOUDON PARK CREMATORY</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE, MARYLAND</i>	
24. FUNERAL DIRECTOR <i>ISOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>MAY 29 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	



1
FOR STATE
HEALTH DEPT.

06439

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06437

1 DECEASED-NAME (Type or Print) ELIZABETH K BOLLIAS			2a DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> Month Day Year MAY 17 1969			2b HOUR 8 PM		
3 SEX F	4 RACE W	5 DATE OF BIRTH AUG 8 1916	6 AGE (In years last birthday) 52 YRS	7 UNDER 1 YEAR MONTHS DAYS	7c UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year MAY 17 1969		
7a BIRTHPLACE (State or foreign country) VA.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTO		
10 CITY OR TOWN OF DEATH ESSEX			11 NAME OF HOSPITAL OR INST TUTION (If not n hospital give street address) 7929 GOUGH ST			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if inst tution. Residence before admission) STATE MD			13b COUNTY BALTO		13c CITY OR TOWN ESSEX	13d INSIDE CITY - MTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 23 NERBAY RD	
14 FATHER'S NAME First Middle Last OSCAR CRICKENBERGER			15 MOTHER'S MA DEN NAME First Middle Last ?					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECUR TY NO		17 INFORMANT ADDRESS JANET SIDENA 23 NERBAY RD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardi-Cerebrovascular DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED None			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE MELVIN B. DAVIS MD			M.D.			22b DATE SIGNED MAY 20 1969		
EXAMINER'S NAME (Type) MELVIN B. DAVIS MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) 6800 HARRINGTON RD DUNDALK MD 21222		
23a BURIAL CREMATION REMOVAL (Specify) BURIAL		23b DATE 5/21/69		23c NAME OF CEMETERY OR CREMATORY ORR LAWN		23d LOCAT ON (City or Town) BALTO. MD.		(County) (State)
24. FUNERAL DIRECTOR J.G. CONNELLY SONS				ADDRESS 300 MA CE		25a REC'D BY REGISTRAR MAY 21 1969		25b REGISTRAR'S SIGNATURE Charles J. [Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be retained for your files.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 13. Page 5 may be retained for your files.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

06440

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06438

1 DECEASED-NAME (Type or print) First Middle Last Ruth E. Bond			2a DATE OF DEATH Month Day Year May 29 1969		2b HOUR 1:55 PM
3 SEX Female	4 RACE white	5. DATE OF BIRTH Sept. 24, 1893		6. AGE (In years last birthday) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Co. Md		
10 CITY OR TOWN OF DEATH Catochville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home	12a USAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b KIND OF BUSINESS OR INDUSTRY		
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b COUNTY Baltimore	13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 3002 Illinois Ave	21227	
14. FATHER'S NAME First Middle Last Louis ARMINGER		15 MOTHER'S MAIDEN NAME First Middle Last Virginia WARD			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b SOCIAL SECURITY NO 220-24-5908	17 INFORMANT Address Mr. Edward L. Bond, Sr. 3002 Illinois Ave.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2501 Diabetic Mellitus a severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, generalized DUE TO OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1964 to 5/29/69, that (I) (we) saw the deceased alive on 5/24/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Dr. Edgar P. Williamson, 2nd		22c DATE SIGNED 6/2/69	22d PHYSICIAN'S NAME (Type)		
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE 6-2-1969	23c NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d LOCATION (City or Town) (County) (State) Dorsey, Howard County, Md.
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a REC'D BY REGISTRAR JUN 3 1969		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06441

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06439

1 DECEASED NAME (Type or print) First Middle Last William A. Bortner			2a DATE OF DEATH Month Day Year May 29, 1969			2b HOUR 1:30 PM				
3 SEX Male		4 RACE White		5 DATE OF BIRTH 12/20/02		6 AGE (In years last birthday) 66 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Co. Md.				
10. CITY OR TOWN OF DEATH Randallstown			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.C.C. Balto. Co. Gen. Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Self-employed			12b KIND OF BUSINESS OR INDUSTRY Real estate	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b COUNTY BALTIMORE		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4508 Keswick Rd.	
14. FATHER'S NAME First Middle Last Louis F. Bortner			15 MOTHER'S MAIDEN NAME First Middle Last Annie Clark							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b SOCIAL SECURITY NO. WW 11 ?		17. INFORMANT Address Lewis D. Bortner Jr. - 1111 Roland Heights					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerotic Heart Disease</u> 123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 1/2 YRS.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>DIABETES MELLITUS - 7 YRS.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>April 19, 1955</u> to <u>May 29, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 16, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Robert W. Garis, M.D.</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>May 29, 1969</u>
22d. PHYSICIAN'S NAME (Type) ROBERT W. GARIS, M.D.		22e. ADDRESS 12 E. BAGER ST., BALTIMORE, MD, 21202								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>6/2/69</u>		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) Baltimore		County Md.		State
24. FUNERAL DIRECTOR Ann Donovan - 3712 Roland Ave.				ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 2 1969		25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

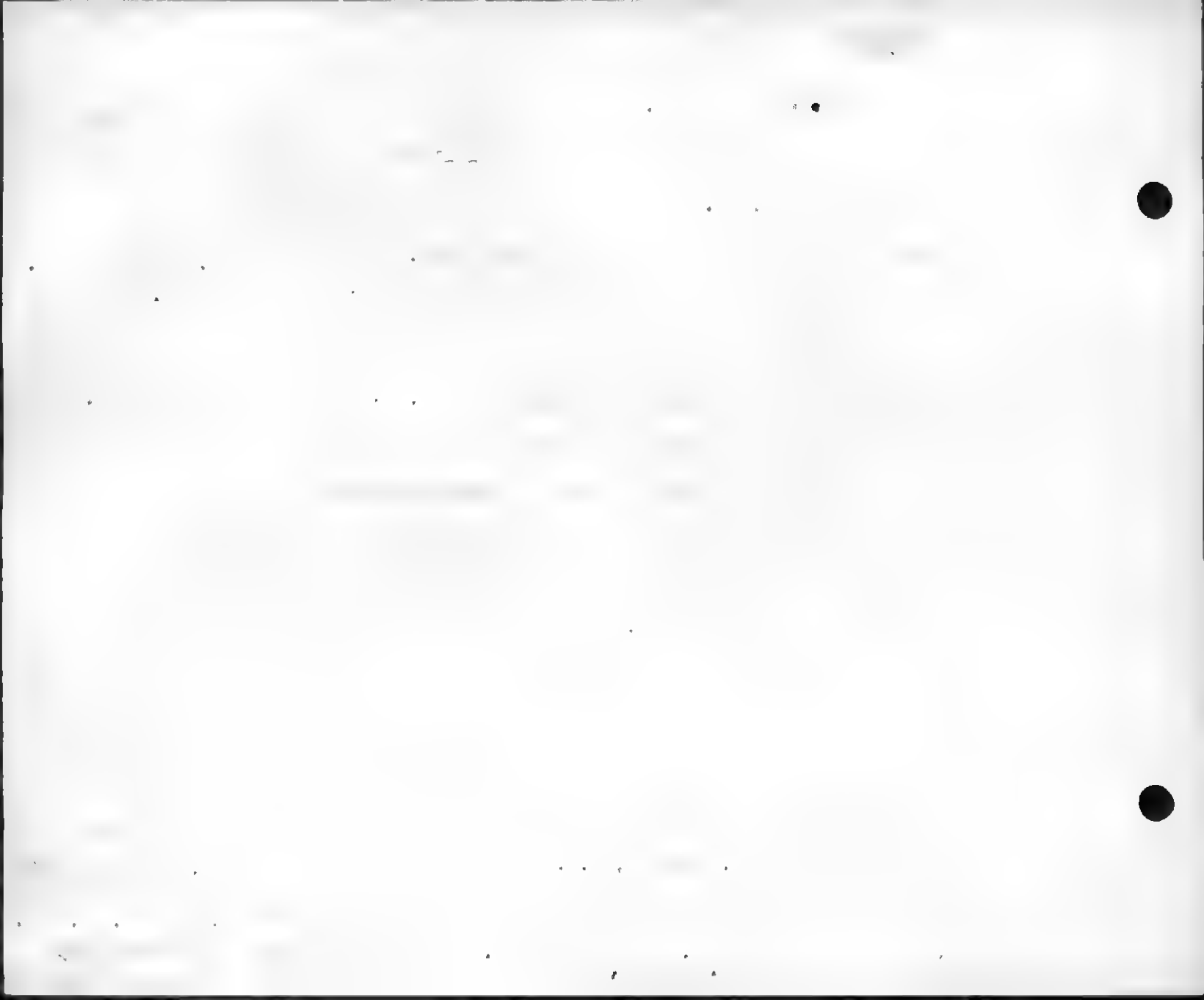
1

06442

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06440

1 DECEASED NAME (Type or print) Edward Lee Bowen			2a DATE OF DEATH Month May Day 24 Year 1969			2b HOUR 9:15AM					
3 SEX Male		4 RACE White		5. DATE OF BIRTH 3-2-1879		6. AGE (in years last birthday) 90 YRS.		7 UNDER 1 YEAR MONTHS 0 DAYS 0		8 UNDER 24 HRS HOURS 0 MIN 0	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.					
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If no hospital give street address) St. Joseph's Hosp.			12a USUAL OCCUPATION (Kind at work done during most of working life, even if retired) Retired-Balto. Transit Co.			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Res. done before admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Baltimore		13d INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 615 Hollen Rd.	
14 FATHER'S NAME First Middle Last John Bowen			15 MOTHER'S MAIDEN NAME First Middle Last Unknown								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b SOCIAL SECURITY NO 213-10-1571			17 INFORMANT Address Edward W. Bowen, 8453 Morvan Rd. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gangrene of small bowel 5-24-69 DUE TO, OR AS A CONSEQUENCE OF (Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last.) (b) Strangulated left inguinal hernia DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a DATE OF OPERATION 5-24-69			19b CONDITION FOR WHICH OPERATION WAS PERFORMED As stated above.			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I (this hospital) attended the deceased from May 23 , 19 69 , to May 24 , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 24 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death.											
22b. SIGNATURE Lawrence F. Misanik, M.D.			22c. ADDRESS 6720 York Road, Towson, Maryland 21204			22e. DATE SIGNED 5-24-69					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/27/1969			23c. NAME OF CEMETERY OR CREMATORY Druid Ridge			23d. LOCATION (City or Town) (County) (State) Pikesville, Balto. Co., Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			25a. REC'D BY REG. STRAR DATE MAY 26 1969			25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon pages 1, 2, and 3 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06443		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		06441	
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
Baby Boy					BRITTAIN	5	Month 24 Day 69 Year
3 SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years most birthday)	
Male	Cau.		5/22/69			69 YRS	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Balto. Co.	U.S.A.				Baltimore Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
Towson			Greater Balto Med. Center				
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Maryland			Balto.				13e. STREET AND NUMBER
							8431 Morven Rd.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME				
First Middle Last			First Middle Last				
Wayne Michael Brittain			Sandra Jean Brittain				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		
No					Chart		
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Hyaline membrane disease							
776.1							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF							
(b) _____							
(c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		HOUR A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 22, 1969, to May 24, 1969, that (I) (we) last saw the deceased alive on May 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
Charles C. Brown, M.D.				5/26/69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Charles C. Brown, M.D.				6701 N. Charles Street			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Cremation		5/26/69		G.B.M.C.		Baltimore, Maryland	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
G.B.M.C. 6701 N. Charles Street				27 1969		Charles Jones	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print) VANCE First L. Middle BROADBENT Last						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 5 Day 11 Year 1969		2b. HOUR 2:15 M		2c. DATE PRONOUNCED DEAD Month 5 Day 11 Year 1969		2d. HOUR 2:15 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9-26-08		6. AGE (In years last birthday) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 			
7a. BIRTHPLACE (State or foreign country) New York XXXXX				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO. Md			
10. CITY OR TOWN OF DEATH RANDALLS TOWN				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO. CO. GENL				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Electrician				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.				13b. COUNTY BALTO.		13c. CITY OR TOWN Quesada		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3604 N. CHAPMAN Rd.			
14. FATHER'S NAME First George Middle Broadbent Last George						15. MOTHER'S MAIDEN NAME First Jean Middle Thomas Last Thomas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO 213-18-747		17. INFORMANT Aime Broadbent-3604 N. Chapman Road				ADDRESS Randallstown, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4122 A.C.V.H.D = Hypertension													
DUE TO, OR AS A CONSEQUENCE OF (b) 													
DUE TO, OR AS A CONSEQUENCE OF (c) 													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Obese male with Arteriosclerosis - Hypertension - Contracted R. Pulmonary - BPH													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
2a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State 							
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion on													
ACTUAL SIGNATURE John F. Schaefer M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MED. CA. EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-12-69	
EXAMINER'S NAME (Type) John F. Schaefer M.D.						ADDRESS (Street, city, town, or county) 							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-15-1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery				23d. LOCATION (City or Town) Baltimore, Maryland (County) (State) 					
24. FUNERAL DIRECTOR Armacost Funeral Chapel-4600 Liberty Hts. Ave						25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE 					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06445

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06443

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR P		
Raymond		E.	Brooks		5 Month 29 Day 69 Year		10:10 M		
3 SEX	4. RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male	Caucasian		10/22/90		78 YRS		IF UNDER 24 HRS HOURS M.N.		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY		
MD.	U.S. A.				Baltimore		Md.		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Towson		Greater Balto. Med. Center		SPRING SETTER		B & O R R			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
MD.		BALTIMORE		CATONSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		131 NEWBERG AVE.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S M A D E N NAME First Middle Last						
NOT KNOWN			NOT KNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)		6b SOCIAL SECURITY NO		17 INFORMANT		Address			
NO		705-03-9374		Mum Colwell Brooks		131 Newberg Ave.			
18. CAUSE OF DEATH (Enter any one cause per line for (a) (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive hemorrhage</u>									
1621 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) } stating the underlying cause lost									
(b) <u>due to erosion of pulmonary artery</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>carcinoma of left lung</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (th's hospital) attended the deceased from <u>5/10</u> , 19 <u>69</u> , to <u>5/29</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (Type)				22e ADDRESS		May 30, 1969			
Rudiger Breitenecker, M.D.				6701 N. Charles Street		21204			
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		6-3-69		Cathedral Cem.		Baltimore Md.			
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
Farley - Carraway				444 Calverville		JUN 9 1969		Charles Judge	

VA 11-14
45M - 1969



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/66

06446

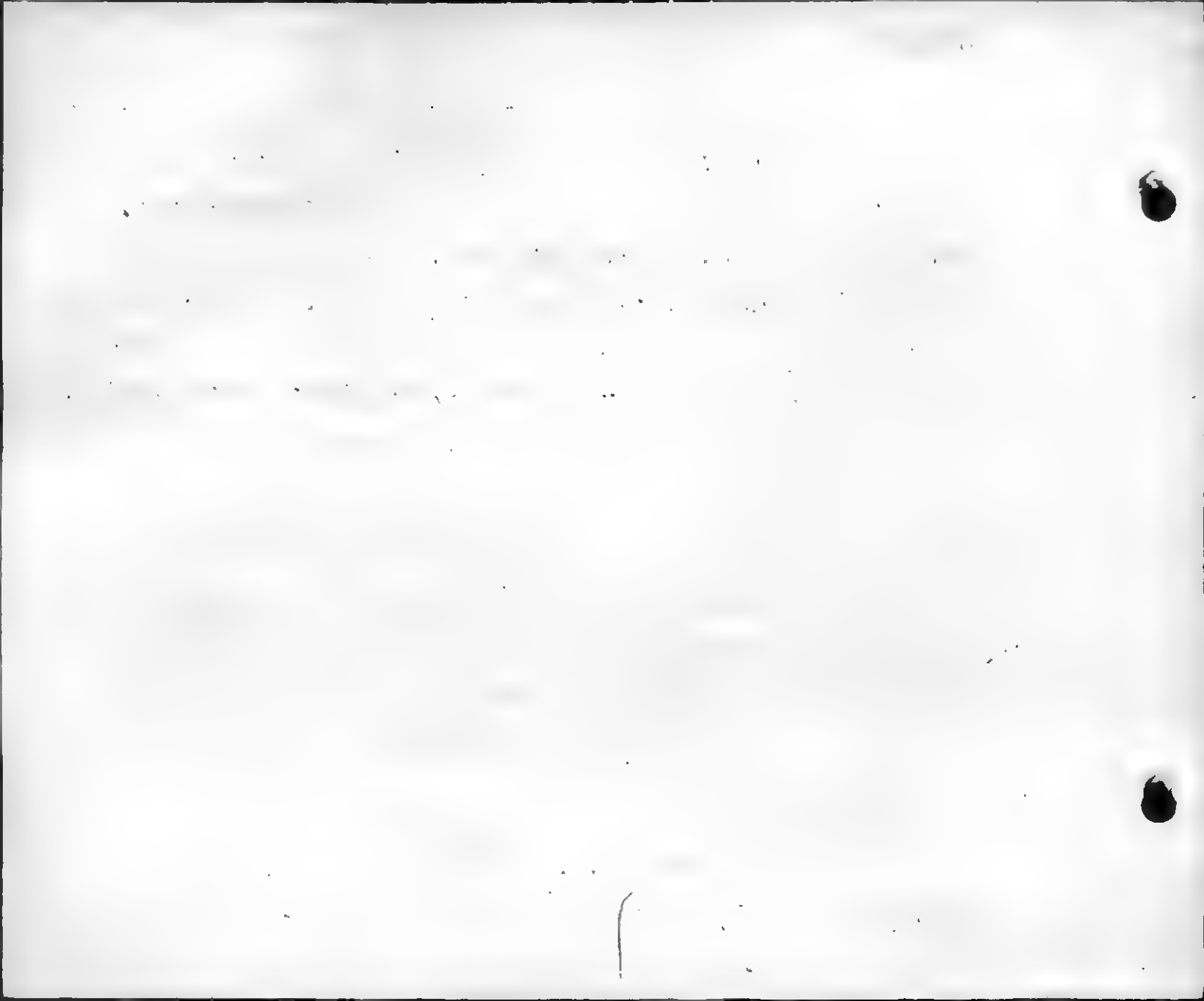
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06444

1 DECEASED-NAME (Type or print) ALBERT First E. Middle BROWN Last		2a DATE OF DEATH Month MAY Day 27 Year 1969		2b. HOUR 7 A M	
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 3/22/07	6 AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign) MD. U.S.A.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore, County, Md		
10 CITY OR TOWN OF DEATH Mount Wilson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b COUNTY CARROLL CO.	13c CITY OR TOWN WESTMINSTER	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER Rt. 6 Box 306 Westminster	
14 FATHER'S NAME First ALBERT Middle BROWN Last		15. MOTHER'S MAIDEN NAME First MARGARET Middle BAYNE Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. 216-01-4934		17. INFORMANT Address Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Carcinoma of the bronchus DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c) 					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Obstructive Airway Disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. 19 Month 5 Day 27 Year 1969 P.M. 	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. 5/22, 1969 City or Town to 5/27, 1969 County State 			
22a. I certify that (I) (this hospital) attended the deceased from 5/22, 1969 to 5/27, 1969 , that (I) (we) last saw the deceased alive on 5/27/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. Newcomer		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS Mount Wilson, Maryland			
23a. BURIAL (CREMATION, REMOVAL) (Specify)	23b. DATE 5/27/69	23c. NAME OF CEMETERY OR CREMATORY St. Luke's Memorial	23d. LOCATION (City or Town) (County) (State) Chesapeake, Md.		
24. FUNERAL DIRECTOR Frank E. ...		ADDRESS 	25a. REC'D BY REGISTRAR DATE 5. 1969	25b. REGISTRAR'S SIGNATURE ...	

MEDICAL CERTIFICATION

1621



1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																		
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																		
CERTIFICATE OF DEATH																		
1. DECEASED NAME (Type or print)			First Edwin			Middle R.			Last Brown			2a. DATE OF DEATH Month 5 Day 11 Year 1969			2b. HOUR M			
3 SEX Male			4. RACE Cau.			5. DATE OF BIRTH 12-15-1908			6. AGE (in years last birthday) 60 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Carroll Co.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.									
10. CITY OR TOWN OF DEATH Perry Hall			1. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 4655 Dundawn Rd.			12a. USUAL OCCUPATION (Kind of work done during most of work-life, even if retired.) Train Director			12b. KIND OF BUSINESS OR INDUSTRY Lehigh Co.									
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Perry Hall			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 4655 Dundawn Road 21236						
4. FATHER'S NAME First Charles			Middle H.			Last Brown			15. MOTHER'S MAIDEN NAME First Ada			Middle Etzler			Last 21236			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) No			16b. SOCIAL SECURITY NO 213-07-8498			17. INFORMANT Julia A. Brown			Address 4655 Dundawn Road Balto. Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Menastatic carcinoma - to Brain, liver, gone, etc.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adeno-Carcinoma - left lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown to</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
9a. DATE OF OPERATION none			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not wh. e <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)			21f. LOCAT ON Street or R.F.D. No City or Town County State												
22a. I certify that (I) (this hospital) attended the deceased from <u>4/16/69</u> , 19 <u>69</u> , to <u>May 11</u> , 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>May 10</u> , 19 <u>69</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (<u>did not</u>) view the body after death.																		
22b. SIGNATURE <u>Theodore E. Evans</u> M.D. DEGREE													ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 5/12/69		
22d. PHYSICIAN'S NAME (Type) Theodore E. Evans, M.D.													22e. ADDRESS 9660 Belair Road-36-Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5-14-1969			23c. NAME OF CEMETERY OR CREMATORY Ever Green Memorial			23d. LOCATION (City or Town) (County) (State) Finksburg Md.									
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236						25a. REC'D BY REGISTRAR DATE MAY 15 1969			25b. REGISTRAR'S SIGNATURE <u>as</u>									

to Brain, liver,
gone, etc. indelinite

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1

<div style="display: flex; justify-content: space-between;"> 06448 MDARYLAND STATE DEPARTMENT OF HEALTH 06446 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. DECEASED NAME (Type or print) LEROY				First Middle Last BUCKINGHAM				2a. DATE OF DEATH Month 5 Day 7 Year 69			2b. HOUR 8:10A
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9/28/96			6. AGE (in years last birthday) 72 YRS		F. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) BALTIMORE MD		7b. CIT. ZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			M.D.		
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) VET. ADM. HOSPITAL		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) TILE SETTER			12b. KIND OF BUSINESS OR INDUSTRY TILE CO.			M.D.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4013 Frederick Avenue			
14. FATHER'S NAME First Middle Last THEODORE BUCKINGHAM				15. MOTHER'S MAIDEN NAME First Middle Last MARGARET RANHAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES (If yes give war or dates of service) WW I		16b. SOCIAL SECURITY NO 212 07 09 38		17. INFORMANT CLIN. RECORDS, VA HOSP. FT HOWARD, MD.			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. 4104 MYOCARDIAL INFARCTION IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CORONARY THROMBOSIS CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/3/69 , 19____, to 5/7/69 , 19____, that (I) (we) last saw the deceased alive on 5/7/69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John D. Talbert, M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/7/69			
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.						22e. ADDRESS VAH FT HOWARD, MD.					
23a. BURIAL, CREMATION, OR OTHER DISPOSITION BURIAL		23b. DATE 5/9/1969		23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.				
24. FLUENTIAL DIRECTOR John D. Talbert, M.D.		ADDRESS COWAN FUNERAL HOME		25a. REC'D BY REGISTRAR MAY 9 1969		25b. REGISTRAR'S SIGNATURE John D. Talbert, M.D.					

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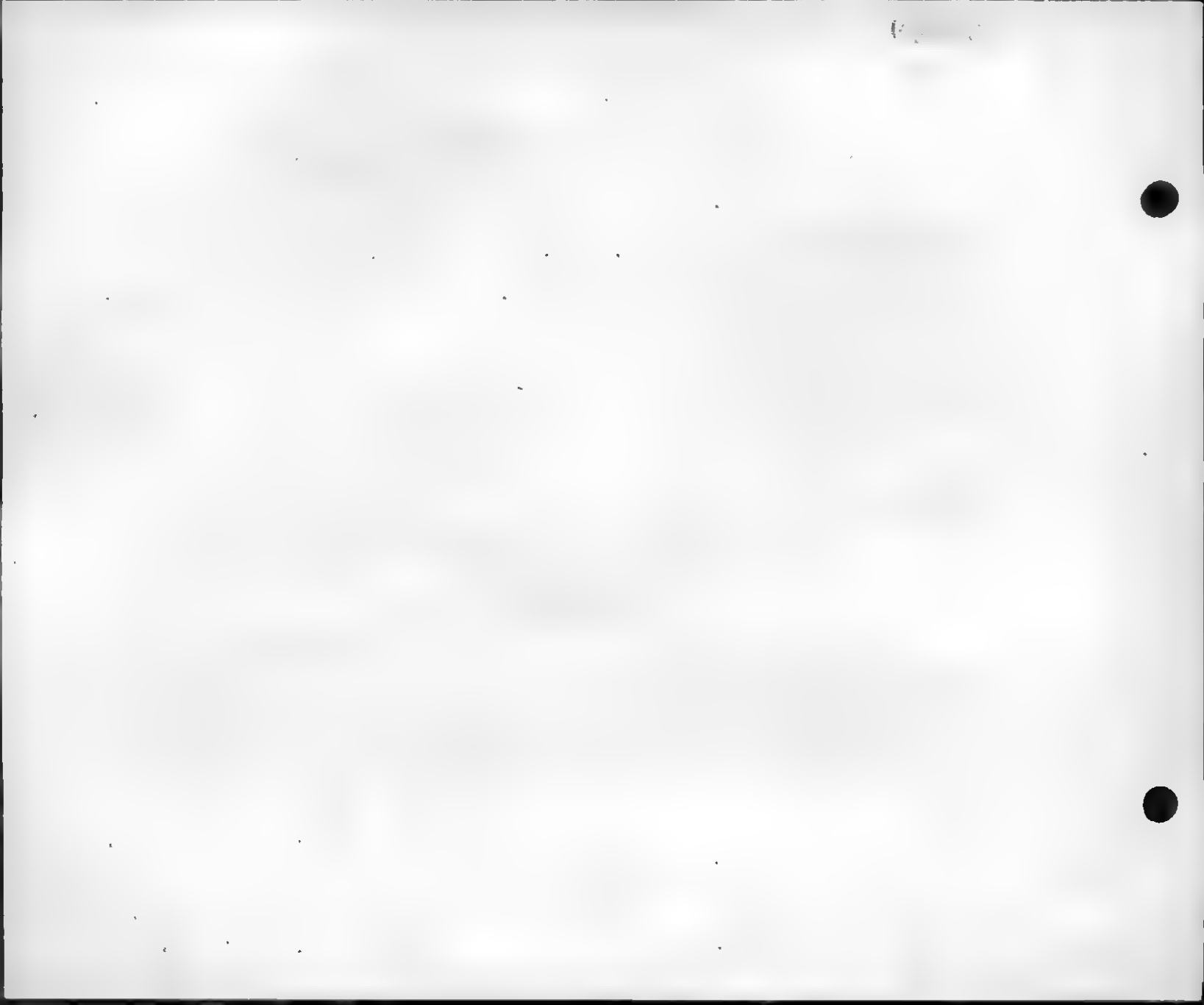
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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06449		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06447	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1 DECEASED-NAME (Type or Print) First Middle Last MARY ELIZABETH BULGEN			2a DATE KNOWN OF DEATH Month Day Year MAY 18 1969		2b HOUR M
3 SEX F	4 RACE W	5 DATE OF BIRTH 7/8/91	6 AGE (In years last birthday) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year MAY 18 1969
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) St. Jos. Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md.		13b COUNTY Balto.		13c CITY OR TOWN Balto.	
14 FATHER'S NAME First Middle Last Gris		15. MOTHER'S MAIDEN NAME First Middle Last unknown		12b KIND OF BUSINESS OR INDUSTRY at home	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO 214-14-4429D		17. INFORMANT ADDRESS Joan Compton, dght. above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William A. Pilsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 5-18-69	
EXAMINER'S NAME (Type) WILLIAM A. PILSBURY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/21/69		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR MAY 21 1969		25b. REGISTRAR'S SIGNATURE William A. Pilsbury	
23d. LOCATION (City or Town) Baltimore, Md.		23e. (County) Baltimore		23f. (State) Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

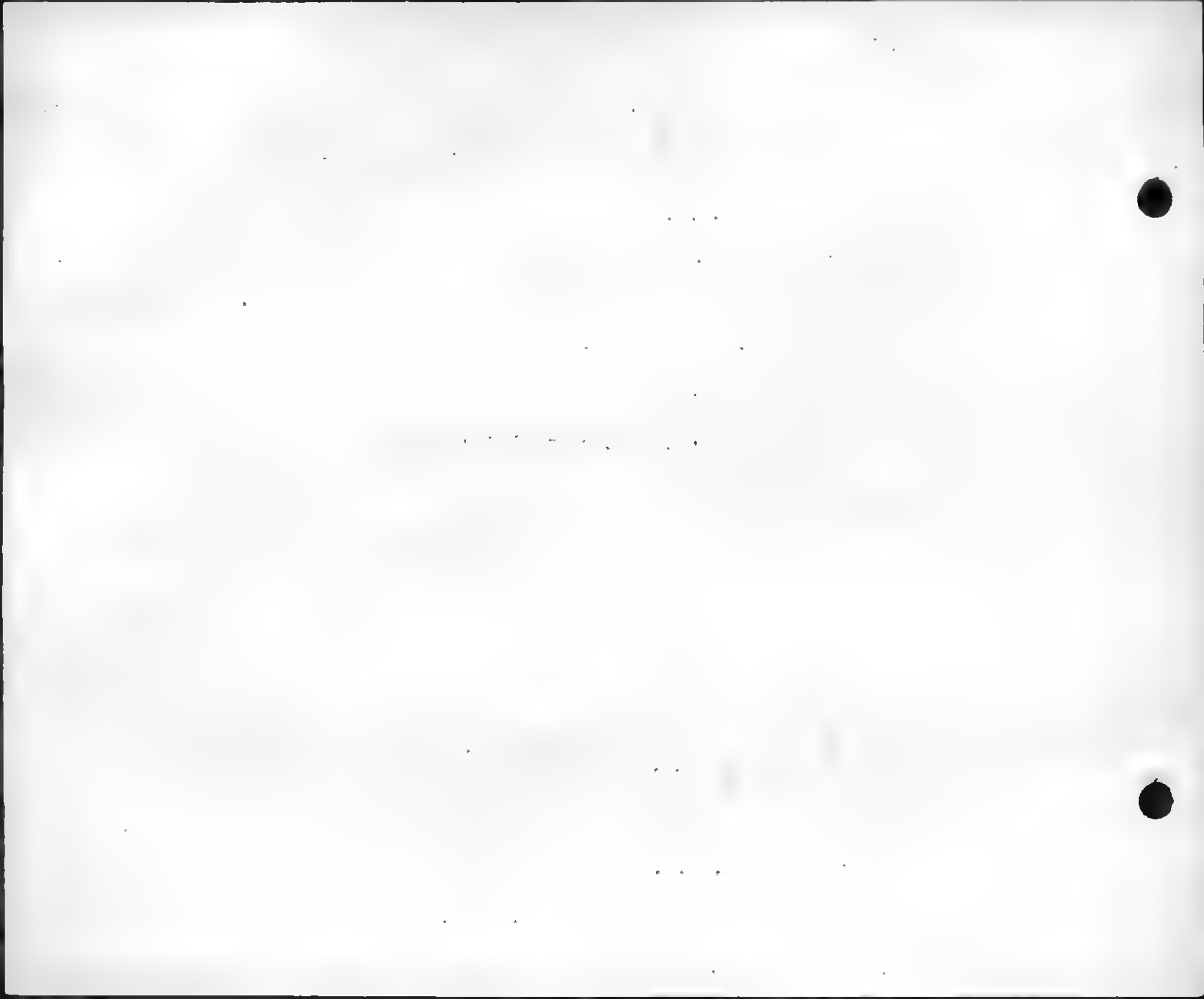
06450

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06448

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
LEROY		LOUIS	BUNCH	MAY 10, 1969		noon		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	WHITE		FEBRUARY 16, 1929		40 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		U.S.A.				BALTIMORE 21204		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE-TOWSON		ST. JOSEPH HOSPITAL		Driver		Anne's Flowers		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND		BALTIMORE				2525 E. MADISON STREET		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
John J. Bunch Sr.		Mary Bialek						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Address				
yes		WV 2 -Marine 220-24-3233		Genevieve Bunch, above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction								
7107 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost.								
DUE TO, OR AS A CONSEQUENCE OF (b) _____								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (A) (this hospital) attended the deceased from May 8, 1969, to May 10, 1969, that (A) (we) last saw the deceased alive on May 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (do) (did not) view the body after death.								
22b. SIGNATURE <i>Lorna Gaudiol</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED MAY 10, 1969		
22d. PHYSICIAN'S NAME (Type) Lorna Gaudiol, M.D.				22e. ADDRESS 7620 YORK ROAD, TOWSON 4, MARYLAND				
23a. BURIAL, CREMATION REMOVAL <input checked="" type="checkbox"/> Burial		23b. DATE 5/14/69		23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 2601 E. Madison St.				25a. REC'D BY REGISTRAR MAY 15 1969		25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06451										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06449																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
First Middle Last Richard Bunke										Month Day Year May 1 1969										11:45 PM																			
3 SEX Male										4 RACE White										5 DATE OF BIRTH Dec. 23, 1895										6 AGE (in years lost-birth day) 73 YRS									
7a. BIRTHPLACE (State or foreign country) Balto.										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH Baltimore Co. Md.									
10 CITY OR TOWN OF DEATH Balto. Md.										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Forest Haven Convalescent Home										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Janitor										12b. KIND OF BUSINESS OR INDUSTRY Vital Rec. Dept									
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md										13b. CITY OR TOWN Baltimore										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 534 N. Milton Ave.									
14 FATHER'S NAME First Middle Last Unknown										15 MOTHER'S MAIDEN NAME First Middle Last Unknown																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes										16b. SOCIAL SECURITY NO 214-40-5043										17 INFORMANT Maude Bunke - 534 N. Milton Ave.																			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATHEROSCLEROTIC CHANGES - MYOCARDIAL INFARCTION</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DISSEMINATED ATERIOLENERGIC CIRCULATORY</u> DUE TO, OR AS A CONSEQUENCE OF <u>CHLORAL</u> (c) <u>CEREBROVASCULAR INFARCTION</u>																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/1/69</u> , 19 <u>69</u> , to <u>5/1/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/1/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE <u>John C. Miller Inc.</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 5/5/69																			
22d. PHYSICIAN'S NAME (Type) John C. Miller Inc.										22e. ADDRESS 6415 Belair Rd																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 5/5/69										23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith																			
										23d. LOCATION (City or Town) (County) (State) Balto. Md.																													
24. FUNERAL DIRECTOR John C. Miller Inc.										ADDRESS 6415 Belair Rd										25a. REC'D BY REGISTRAR MAY 8 1969																			
																				25b. REGISTRAR'S SIGNATURE <u>John C. Miller</u>																			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and on any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTIMATED DEATH		2b. HO. R.	
JOHN C. BURDETTE						MAY 7 1969		11:16 P	
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
M	W	SEPT. 12, 1895	73 YRS					Month Day Year 19 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
BALTO. MD		U.S.A.				BALTIMORE Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a. USUA. OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
PIKEVILLE		MT. WILSON LANE		RETIRED DRAFTERMAN		B.O. R.A.			
13a. USUAL RES DENCE (Where deceased lived, if institution residence before admision) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD		BALTIMORE		PIKEVILLE				BOX 228 MT WILSON LA	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
			Pat ELLA						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT		ADDRESS			
		705-05-7286		JOHN C. BURDETTE JR		3614 CROFTON RD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion									hr.
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
none								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
none		19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
		none							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE D. D. Caples				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples, M.D.				6 Hanover Rd.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> REGISTERSTOWN, MD.		5-8-69	
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		MAY 11, 1969		MORELAND MCH PT		BALTO. MD			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
WITZKE - 4101 EDMONDSON AVE BALTO.						MAY 12 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 10-1-68
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year		2b HOUR 6:30 PM	
William			Daniel		Bush, Sr.				5 8 69			
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		10-29-98			70 YRS.					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Obern, N. Dakota			USA				Baltimore Md					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Baltimore			St. Joseph's Hospital			Retired Driver-Trucking						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Maryland				Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2505 Linwood Road		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last			
Herman			Bush						Florence Rehardt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT			Address				
Yes			W W 1		213-01-4523			Mrs. Mary Garlock (Same)				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory insufficiency												
DUE TO, OR AS A CONSEQUENCE OF 1. congestive heart failure;												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2. Bronchopneumonia.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
Adenocarcinoma of the prostate with bone metastasis.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (X) (this hospital) attended the deceased from May 3, 1969, to May 8, 1969, that (X) (we) last saw the deceased alive on May 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Ines Cilliani, M.D.								DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED May 9, 1969		
22d PHYSICIAN'S NAME (Type)								22e ADDRESS				
								7620 York Road, Towson, Md. 21204				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			5/12/69.		Parkwood Cemetery			Baltimore, Md.				
24 FUNERAL DIRECTOR						ADDRESS			25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc. Balto. Md. 21214									MAY 12 1969		[Signature]	

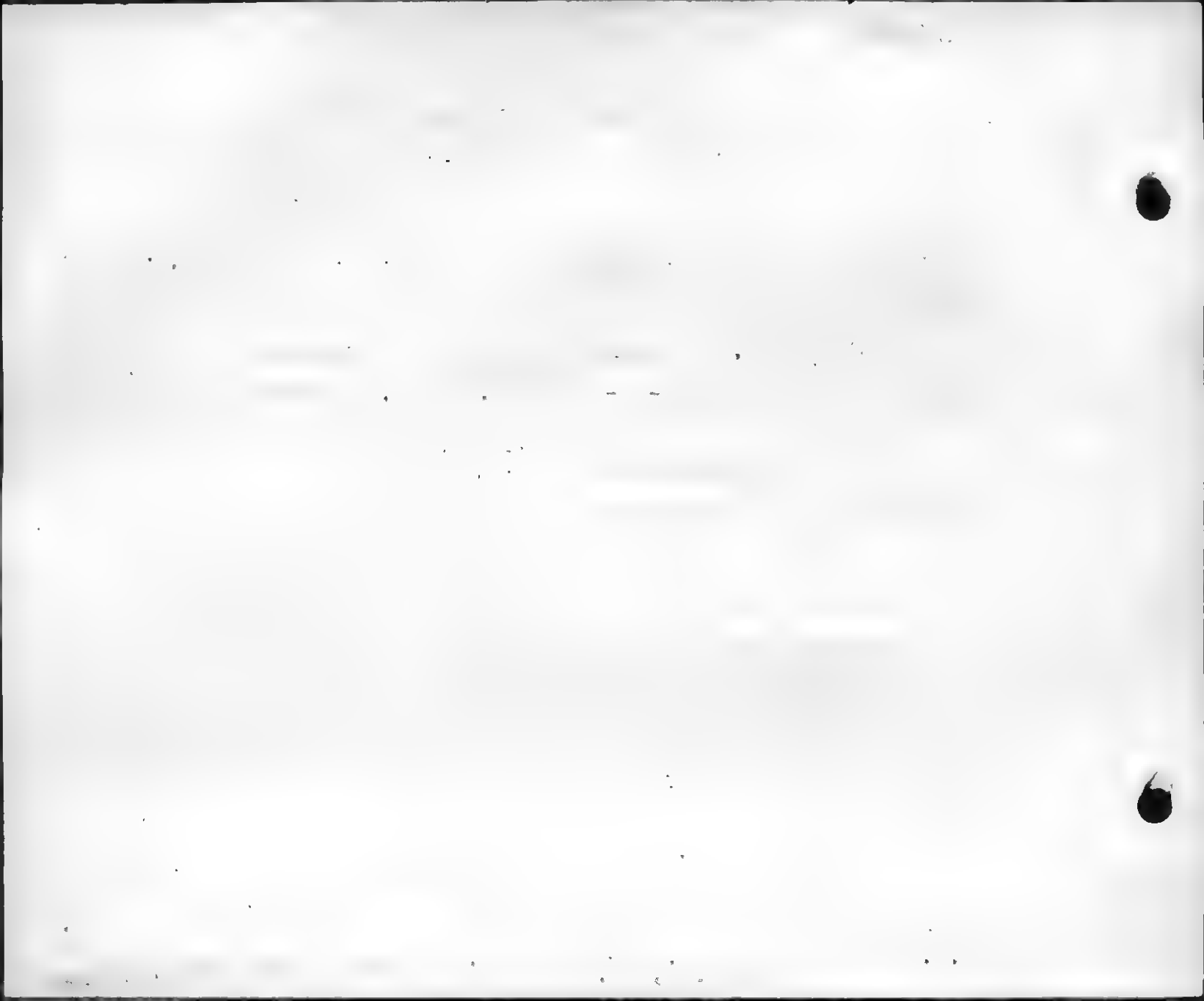
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VR A15
30M REV. 7-64

06454										06452														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or print)			First		Middle		Last			2a DATE OF DEATH			Month		Day		Year		2b HOUR					
			John .		Patrick		Callanan			May 26,			1969						12:05					
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS										
Male			White			9-3-1919			49			YRS.		MONTHS		DAYS		HOURS						
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 COUNTY OF DEATH															
Baltimore			US			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Baltimore															
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY															
Towson			St. Joseph Hospital			F.M.C. Corp. Chem. Engineer																		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER												
Maryland			Baltimore			Baltimore						109 Beachdale Rd. 21210												
14 FATHER'S NAME			First		Middle		Last			15 MOTHER'S MAIDEN NAME			First		Middle		Last							
			Michael J.				Callanan						Margaret				Scallion							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address															
No			213-12-8391			Mrs. Ann W. Callanan			(Same)															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) Chronic renal failure secondary to chronic																								
pyelonephritis.																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																								
(b)																								
DUE TO, OR AS A CONSEQUENCE OF																								
(c)																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)					21f LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from May 12, 1969, to May 26, 1969, that (A) (we) last saw the deceased alive on May 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE										22c DATE SIGNED														
[Signature]										May 26, 1969														
22d. PHYSICIAN'S NAME (Type)										22e ADDRESS														
Samuel C. H. Lee, M.D.										7620 York Road, Towson, Md. 21204														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					5/27/69					New Cathedral					Baltimore Md.									
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE				
H.W. Jenkins & Sons Co.										4905 York Rd.										DATE MAY 27 1969 [Signature]				
Balto. 12, Md.																								

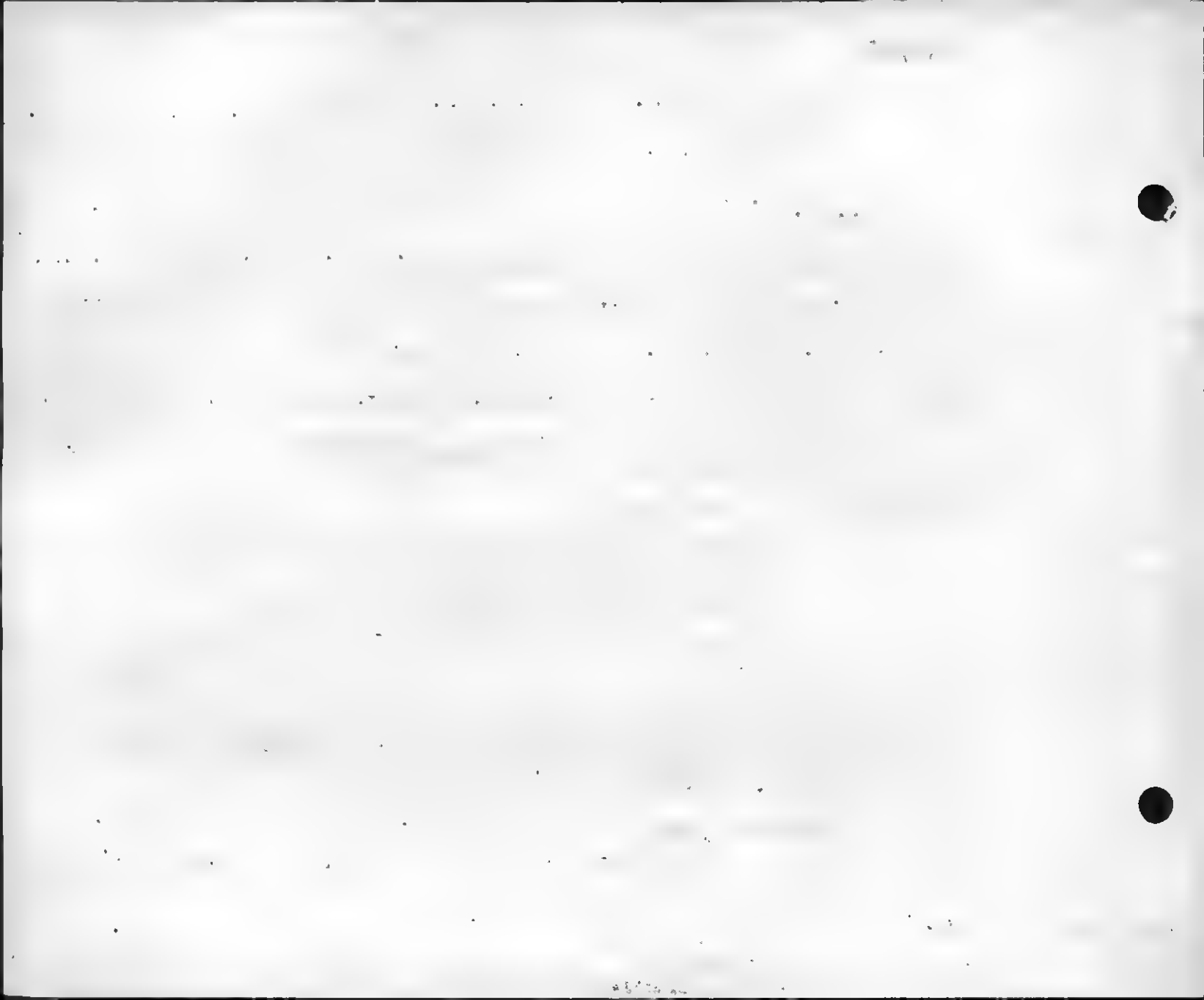


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VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <i>William J. Carle, Jr.</i>					2a. DATE OF DEATH <i>May 16, 1969</i>			2b. HOUR <i>9 P.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>July 19, 1910</i>		6. AGE (in years lost birthday) <i>58</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore County, Md.</i>			
10. CITY OR TOWN OF DEATH <i>Catonsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>218 Beaumont Ave.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Asst. Actuary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S.F. &</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Catonsville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>218 Beaumont Avenue</i>	
14. FATHER'S NAME First Middle Last <i>William J. Carle, Sr.</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Walburger Winters</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or (unknown) <i>No</i> (If yes give year or dates of service) <i>---</i>		16b. SOCIAL SECURITY NO. <i>215-07-8279</i>		17. INFORMANT Address <i>Mrs. Fern R. Carle-218 Beaumont Ave.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>150X Carcinoma of Esophagus</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>1 year</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 15, 1944</i> , to <i>May 16, 1969</i> , that (I) (we) last saw the deceased alive on <i>May 13, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Kennard Yaffe MD</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/17/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>KENNARD YAFFE MD</i>				22e. ADDRESS <i>5301 FOREST PARK AVE</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/20/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery - Baltimore, Md.</i>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Sterling Funeral & Burial</i>		ADDRESS <i>736 Edmondson Ave. Catonsville, Md. 21228</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 20 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



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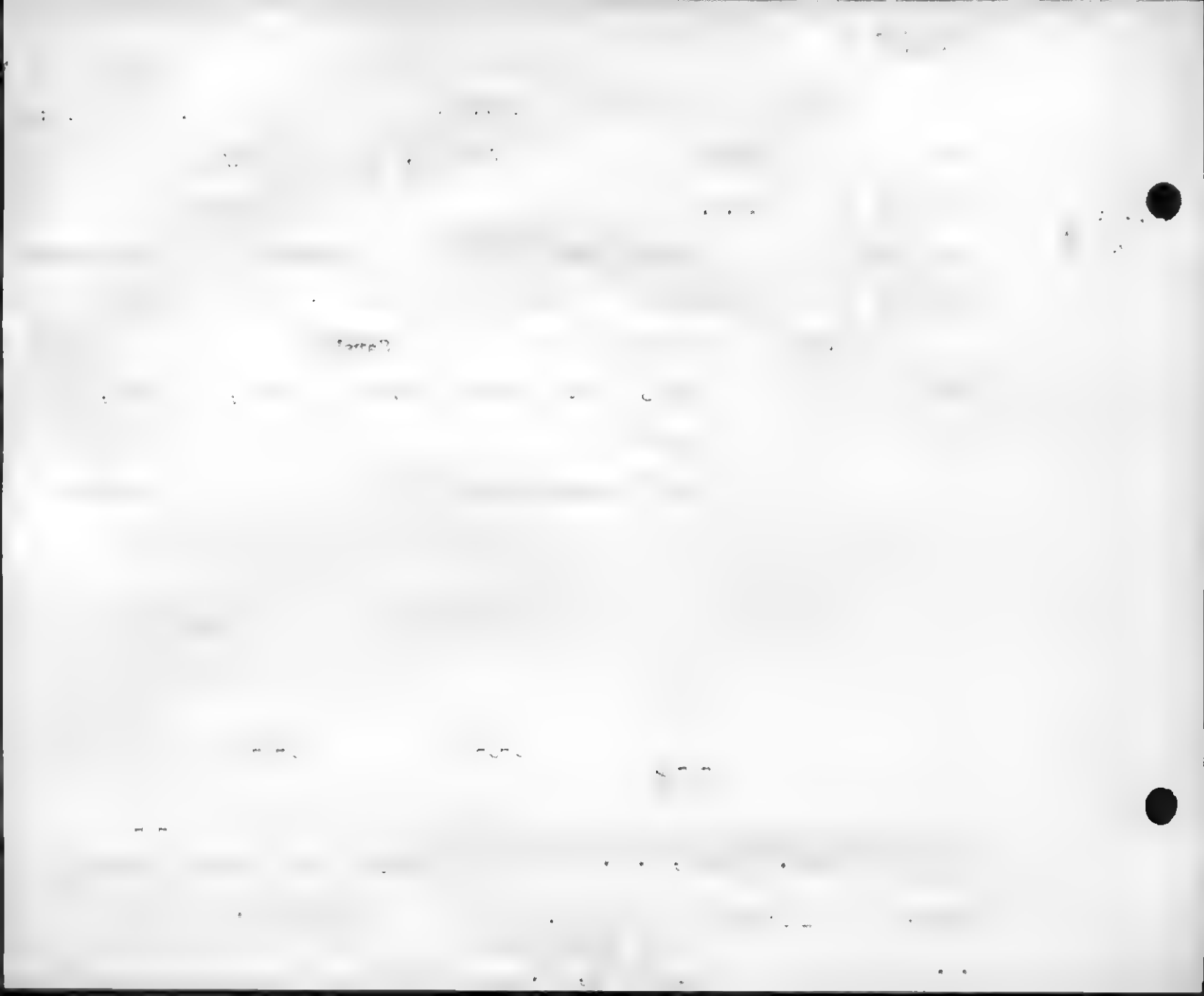
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
WALTER			CARLSON			5 Month 7 Day 69 Year			10:25 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		White		11/18/1894		73 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
SWEDEN		U.S.A.				BALTO.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTO. MD.			CHESAPEAKE MANOR N.H.								
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MD.			BALTO.		Lutherville MD.				FALLS RD RFD #1		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Johannes			CARLSON			Charlotte			Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
						Joan Naylor, Wyman Park Apt., 39th Beech					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1621 Metastatic Carcinoma of Lung										6 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) Carcinoma of Lung	
										(c) 1 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year								
			P.M. 19								
21a. INJURY OCCURRED			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			21g. STATE		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No			City or Town		
22a. I certify that (I) (this hospital) attended the deceased from 5/1/69, to 7 May, 19 69, that (I) (we) last saw the deceased alive on 6 May 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DEGREE			22d. ADDRESS			22e. DATE SIGNED		
Charles O'Donnell			DEGREE			7501 York Road, Balto., Md. 21218			5/8/69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Dr. O'Donnell											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Cremation			5/8/69			Loudon Park Crematory			Balto., Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Witzke, 4101 Edmondson Ave., Baltimore M.d.			21229			MAY 8 1969			Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
GEORGE			ALBERT		CARROLL		Month MAY 4, 1969		Day Year 11:30 P		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER YEAR MONTHS DAYS		
MALE		NEGROID		JULY 28, 1888			80		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY		
MARYLAND		U.S.A.		BALTIMORE			BALTIMORE		CONSTRUCTION		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address)			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD			HOSPITAL VETERANS ADMINISTRATION			LABORER					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission - STATE)			13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER				
MARYLAND			ANNE ARUNDEL		ANNAPOLIS		424 CHESTER AVENUE				
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last		
CHARLES			Edward		CARROLL		Sarah		NMN COLBERT		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT		Address				
YES			216 32 7972		CLINICAL RECORDS, VA HOSP, FT HOWARD, MD						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA										DAYS	
DUE TO, OR AS A CONSEQUENCE OF CHRONIC GLOMERULONEPHRITIS										UNKNOWN	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? none				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or RFD No City or Town County State						
22a. I certify that (X) (th) (his) (hospital) attended the deceased from 5-3-69, 19, to 5-4-69, 19, that (X) (we) last saw the deceased alive on 5-4-69, 19, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.											
22b SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED		
JOHN D. TALBERT, M. D.									5-5-69		
22d PHYSICIAN'S NAME (Type)		23a NAME OF CEMETERY OR CREMATORY			23b LOCATION (City or Town) (County) (State)		23c LOCATION (City or Town) (County) (State)				
BURIAL		Annapolis Neck			ANNAPOLIS, MARYLAND						
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE						
C.E. Hicks, III		HICKS FUNERAL HOME AN APOLIS, MD.			MAY 9 1969						

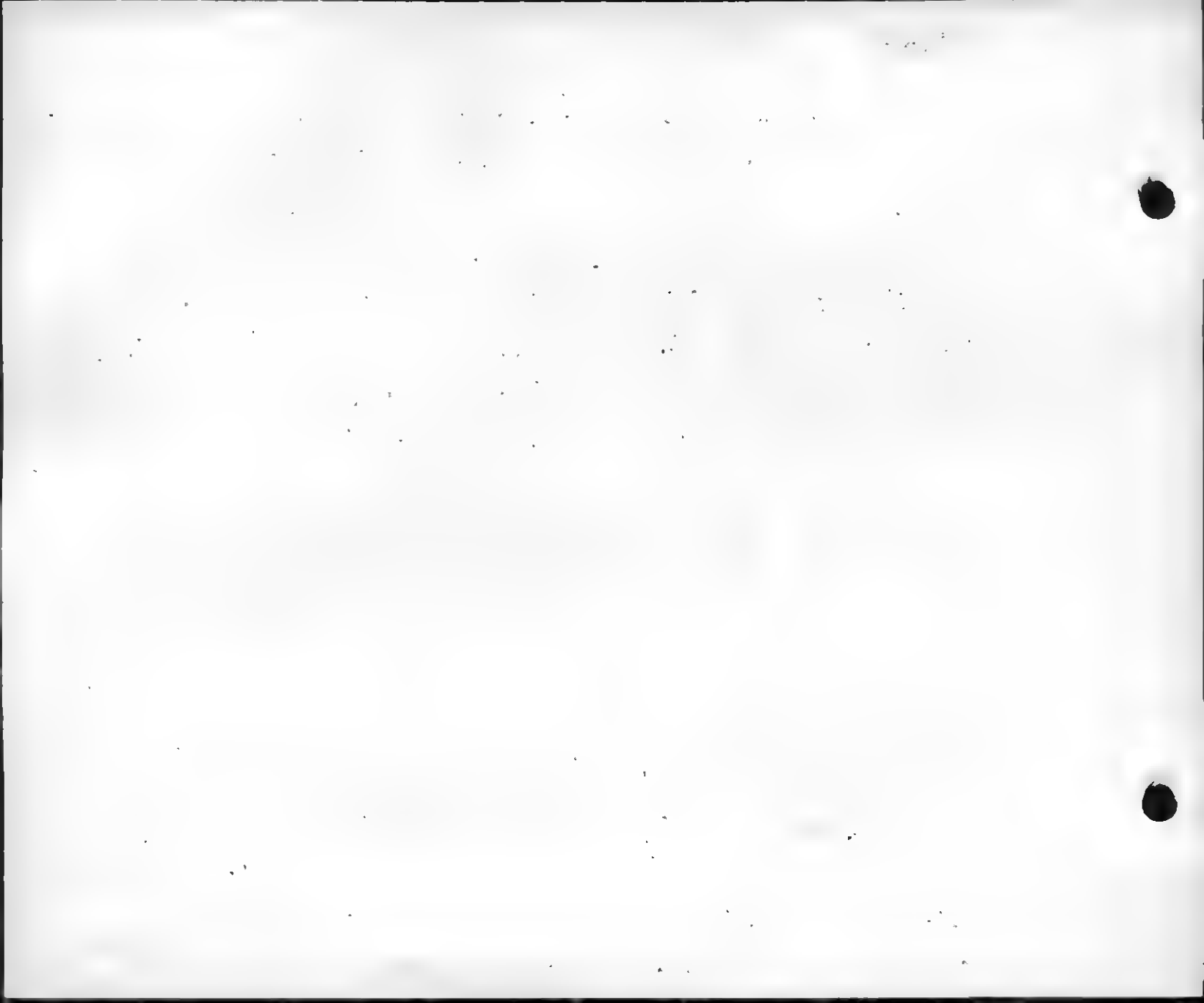


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
06458										06456	
1. DECEASED-NAME (Type or print) Augusta H. Cashell				2a. DATE OF DEATH Month May Day 28 Year 1969				2b. HOUR 11 35 PM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH July 29, 1882				6. AGE (In years last birthday) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				Md.	
10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Aged Womens + Mens Home				2c. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House Wife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Old Court Rd.	
14. FATHER'S NAME Wallace				Middle S		Last Mabbett		15. MOTHER'S MAIDEN NAME Margaret		Middle Getz	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No				16b. SOCIAL SECURITY NO. 215-54-1689		17. INFORMANT DAISY E. Hamilton, 615 Chestnut Ave. (4)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cerebral Vascular Accident											
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD											
DUE TO, OR AS A CONSEQUENCE OF (c) Years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 19, 1969 , to May 28, 1969 , that (I) (we) last saw the deceased alive on May 19, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Monland E Day MD								DEGREE		22c. DATE SIGNED May 29, 1969	
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS 4-E-33rd St Baltimore Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE May 31, 69		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown						ADDRESS		25a. REC'D BY REG STRAR JUN 3 1969		25b. REGISTRAR'S SIGNATURE [Signature]	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>06459</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>06457</div> <div>2b HOUR</div> </div>									
<div> <div>1 DECEASED-NAME (Type or Print)</div> <div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div>HARRY EDWARD CAWOOD</div> </div> <div> <div>2a DATE KNOWN OF DEATH</div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div> <div>5</div> <div>9</div> <div>1969</div> </div> </div> <div> <div>2b HOUR</div> <div>23</div> <div>55</div> </div>									
<div> <div>3 SEX</div> <div>M</div> <div>4 RACE</div> <div>W</div> <div>5 DATE OF BIRTH</div> <div>11-20-1989</div> <div>6 AGE (In years last birthday)</div> <div>79</div> <div>7 YRS</div> <div>8 MONTHS</div> <div>9 DAYS</div> <div>10 HOURS</div> <div>11 MIN</div> </div> <div> <div>2c DATE PRONOUNCED DEAD</div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div> <div>5</div> <div>9</div> <div>1969</div> </div> </div> <div> <div>2d HOUR</div> <div>23</div> <div>55</div> </div>									
<div> <div>7a BIRTHPLACE (State or foreign country)</div> <div>MD.</div> <div>7b CITIZEN OF WHAT COUNTRY?</div> <div>USA</div> <div>8 MARRIED</div> <div>NEVER MARRIED</div> <div>WIDOWED</div> <div>DIVORCED</div> <div>9. COUNTY OF DEATH</div> <div>BALTO.</div> </div>									
<div> <div>10. CITY OR TOWN OF DEATH</div> <div>BALTO.</div> <div>11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>5723 Edmondson Ave</div> <div>12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)</div> <div>RETIRED - Transit</div> <div>12b KIND OF BUSINESS OR INDUSTRY</div> <div>Company</div> </div>									
<div> <div>13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE</div> <div>MD.</div> <div>13b COUNTY</div> <div>BALTO.</div> <div>13c CITY OR TOWN</div> <div>Balto</div> <div>13d INSIDE CITY LIMITS?</div> <div>YES</div> <div>NO</div> <div>13e STREET AND NUMBER</div> <div>5723 EDMONDSON</div> </div>									
<div> <div>14 FATHER'S NAME</div> <div>First</div> <div>Middle</div> <div>Last</div> <div>Edwin UNKNOWN Cawood</div> <div>15 MOTHER'S MAIDEN NAME</div> <div>First</div> <div>Middle</div> <div>Last</div> <div>UNKNOWN</div> </div>									
<div> <div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>NO</div> <div>16b. SOCIAL SECURITY NO.</div> <div>213-10-3024</div> <div>17. INFORMANT</div> <div>MRS. ASIA B. CAWOOD</div> <div>ADDRESS</div> <div>SAME</div> </div>									
<div> <div>18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))</div> <div>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</div> <div>4109</div> <div>MASSIVE CORONARY</div> <div>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div> <div>(b)</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c)</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> </div> <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>MINUTES</div> </div>									
<div> <div>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</div> <div>DIABETES</div> <div>MENHITUS</div> </div>									
<div> <div>19a. DATE OF OPERATION</div> <div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div> <div>20. AUTOPSY?</div> <div>YES</div> <div>NO</div> </div>									
<div> <div>21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING</div> <div>21b TIME OF INJURY Month, Day, Year</div> <div>21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div> </div>									
<div> <div>21d INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK</div> <div>21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div> <div>21f LOCATION Street or R.F.D. No. City or Town County State</div> </div>									
<div> <div>22a I certify that I took charge of the remains described above, held on</div> <div>Autopsy</div> <div>Inspection</div> <div>Inquiry</div> <div>and in my opinion death resulted from:</div> <div>Natural causes</div> <div>Accident</div> <div>Suicide</div> <div>Homicide</div> <div>Undetermined manner</div> </div>									
<div> <div>ACTUAL SIGNATURE</div> <div>EXAMINER'S NAME (Type)</div> <div>JOHN F. SCHAEFER M.D.</div> <div>CHIEF MEDICAL EXAMINER</div> <div>ASSISTANT MEDICAL EXAMINER</div> <div>DEPUTY MEDICAL EXAMINER</div> <div>ADDRESS (Street, city, town or county)</div> <div>22b DATE SIGNED</div> <div>5-9-69</div> </div>									
<div> <div>23a BURIAL CREMATION, REMOVAL (Specify)</div> <div>23b DATE</div> <div>23c NAME OF CEMETERY OR CREMATORY</div> <div>23d LOCATION (City or Town) (County) (State)</div> </div>									
<div> <div>24 FUNERAL DIRECTOR</div> <div>ARMACOST - 4600</div> <div>ADDRESS</div> <div>LIBERTY HIGTS. AVE</div> <div>25a REC'D BY REGISTRAR</div> <div>25b REGISTRAR'S SIGNATURE</div> </div>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

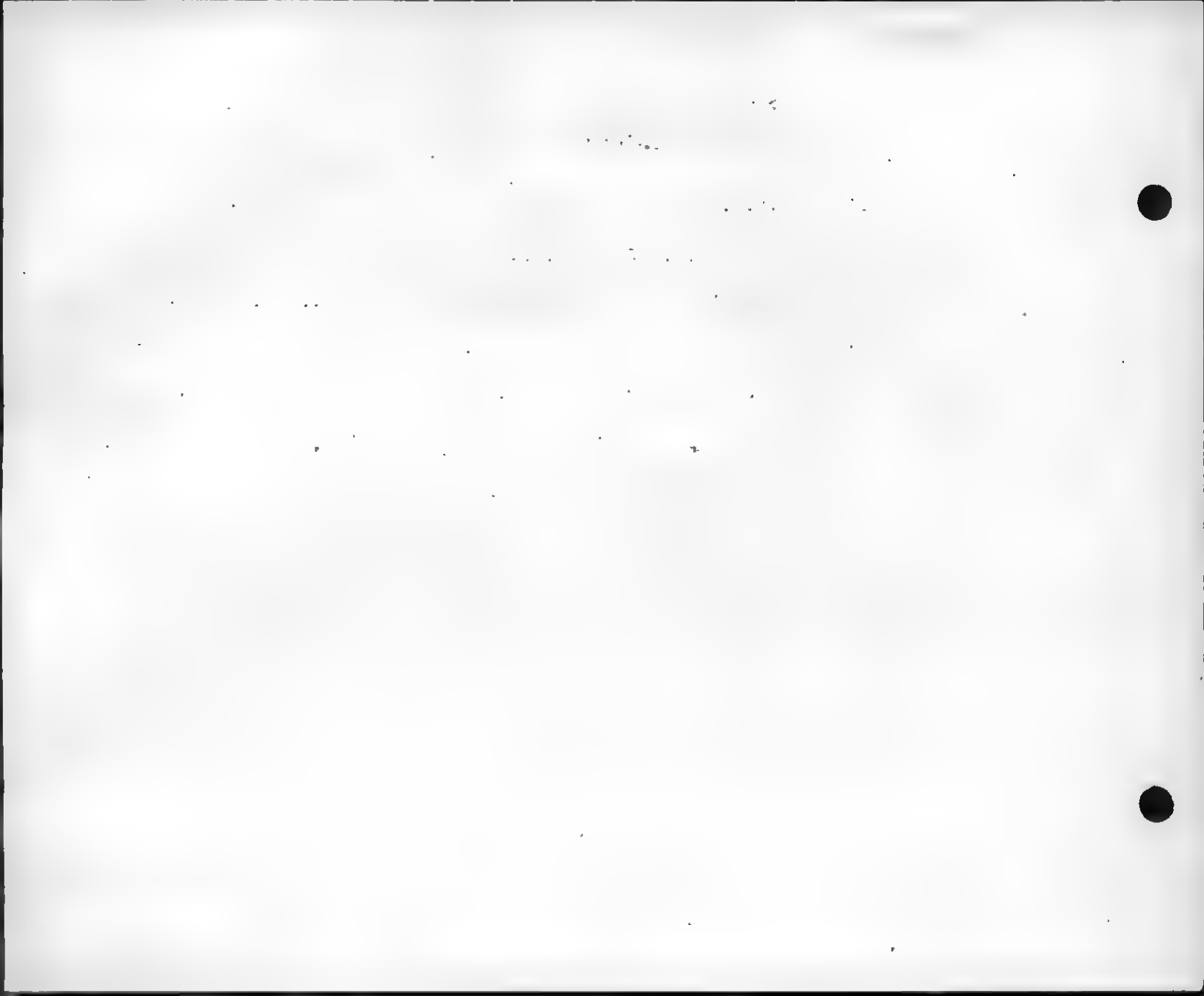
112 06460

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06458

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) DONALD PRESTON COCKEY			First Middle Last		2a DATE OF DEATH Month 9 , Day 1969 Year			2b HOUR M		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH November 25, 1925			6 AGE (In years last birthday) 43 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md.	
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. G. B. M. C.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Machinist			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Timonium		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 125 Cinder Road		
14 FATHER'S NAME First Middle Last Jeremiah Cockey			15 MOTHER'S MAIDEN NAME First Middle Last Mary Bowen							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO (If yes, give war or dates of service) W.W. Two		17 INFORMANT Mrs. Betty Cockey, Same as # 13			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recent Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hr. 4 1/2 wks										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from 4/5 , 19 67 , to 5/5 , 19 69 , that (1) (we) last saw the deceased alive on 5/5 , 19 69 , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Lawrence F. Solomon MD DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 9, 1969			
22d. PHYSICIAN'S NAME (Type) Lawrence F. Solomon, M.D.					22e. ADDRESS 3600 LOCKHART DR.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE May 12, 1969		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Finksburg, Maryland				
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204					25a. REC'D BY REGISTRAR DATE MAY 12 1969		25b. REGISTRAR'S SIGNATURE Wm. Cook-Brooks			



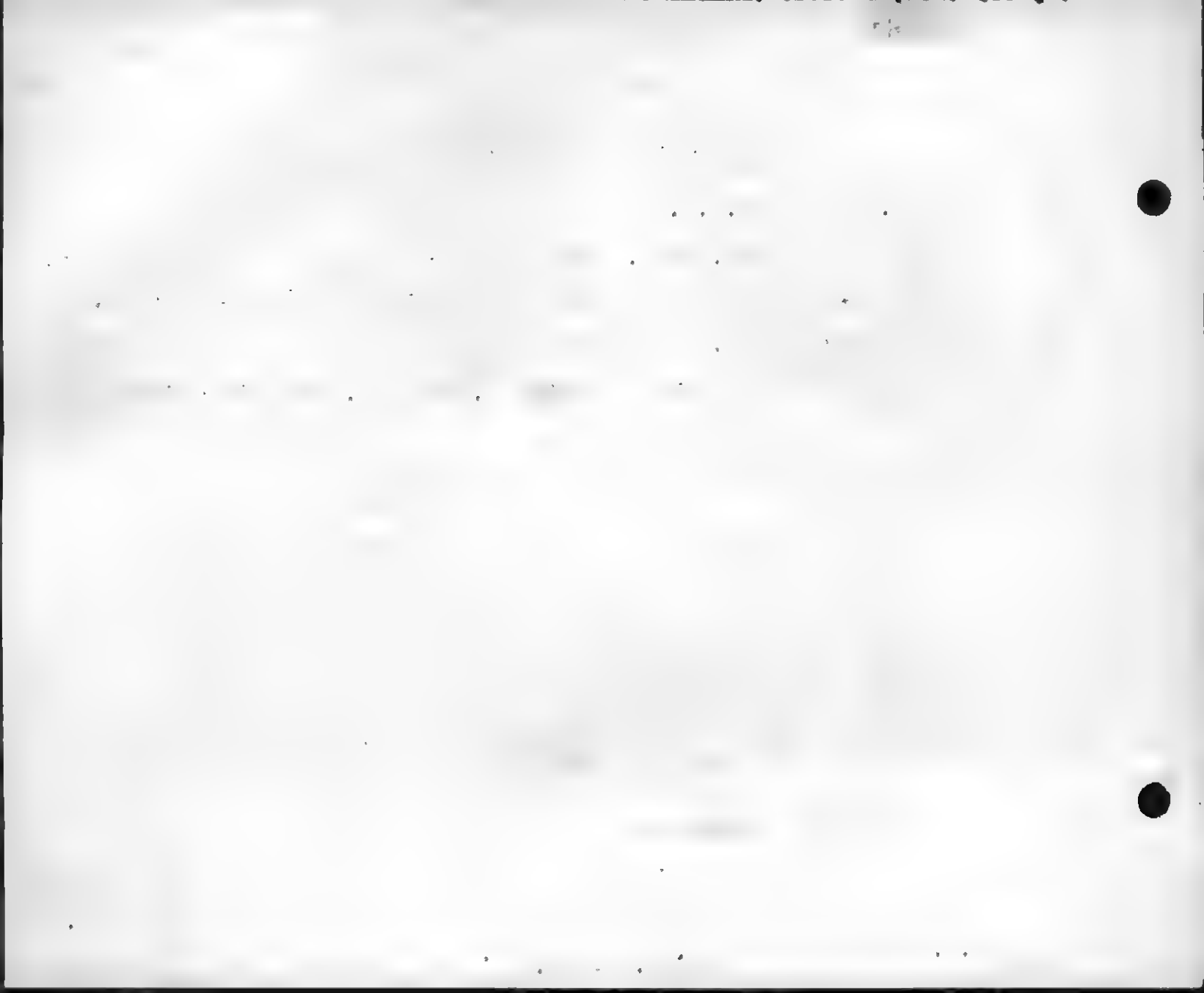
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VR A15
45M 1

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2c. DATE OF DEATH			2b. HOUR
Katie			A.		Colbert	Month 5 Day 14 Year 69			6:50A _M
3 SEX		4. RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS	
Female		Caucasian		12/28/1886		82 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CT ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				Baltimore		Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INST T JT ON (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even retired)		12b KIND OF BUSINESS OR INDUSTRY			
Towson		Gr. Balto. Medical Center		Housewife		Own Home			
13a USUAL RES DENCE (Where deceased lived, if institution- Res dence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.				Baltimore				1202 W. 40th St.	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First
Charles			F.		Halley	Mary			Jane
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No			216-46-7487		Mrs. Joseph A. Denisch		8 Nightingale Way		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) <u>Advanced carcinoma of uterus</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from April 28, 1969, to May 14, 1969, that (I) (we) last saw the deceased alive on May 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE						DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	
22c DATE SIGNED						May 14, 1969			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
John E. Adams, M.D.						6701 N. Charles Street			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		5/17/1969		Loudon Park		Baltimore		Md.	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.						DATE MAY 15 1969		J. Williams Judge	

MEDICAL CERTIFICATION

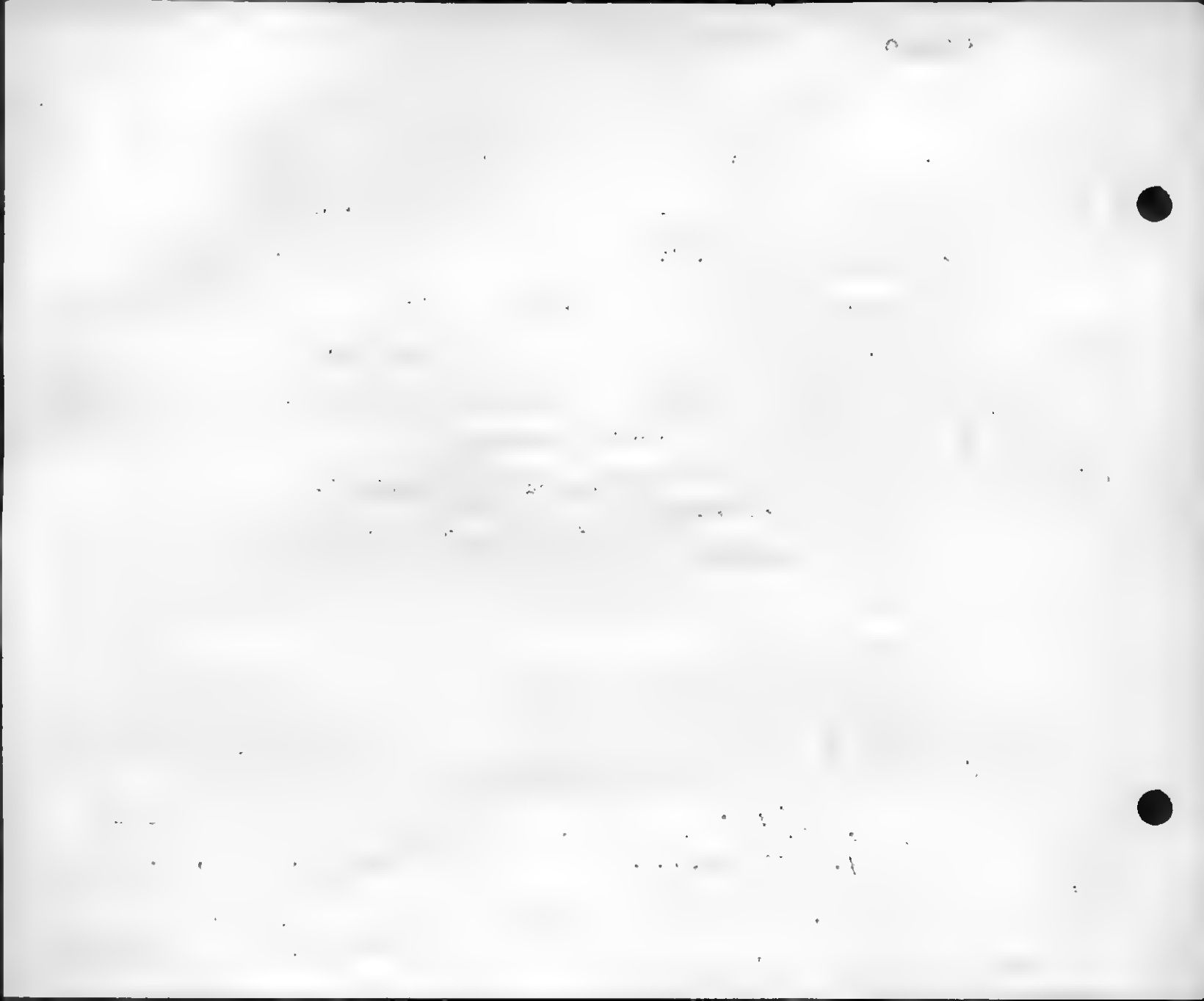


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (1)
304 REV 11-59

<div style="display: flex; justify-content: space-between;"> 06462 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06460 </div>									
1. DECEASED NAME (Type or print) MARGUERITE				First Middle Last CONNOLLY		2a. DATE OF DEATH Month May Day 24 Year 1969		2b. HOUR 5:45AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH 12-16-1890		6 AGE (In years last birthday) 78 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		Md	
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY —		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 304 Tunbridge Road	
14 FATHER'S NAME First Middle Last Michael J. Kram				15. MOTHER'S MAIDEN NAME First Middle Last Caroline Bundschu					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 216-46-9540		17 INFORMANT Address Dr. Harry J. Connolly, 5221 Springlake Way			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Terminal pneumonia									
DUE TO, OR AS A CONSEQUENCE OF Cerebrovascular thrombosis with									
(b) xxxxxxx left hemiplegia									
DUE TO, OR AS A CONSEQUENCE OF Generalized arteriosclerosis									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 1, 1969 , to May 24, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 24, 1969 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <i>A. Villifania</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>						22c. DATE SIGNED 5-24-69			
22d. PHYSICIAN'S NAME (Type) A. Villifania, M.D.						22e. ADDRESS 7620 York Road, Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 27, 1969		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home 4210 Belair Road.						25a. RECEIVED BY REGISTRAR DATE MAY 28 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

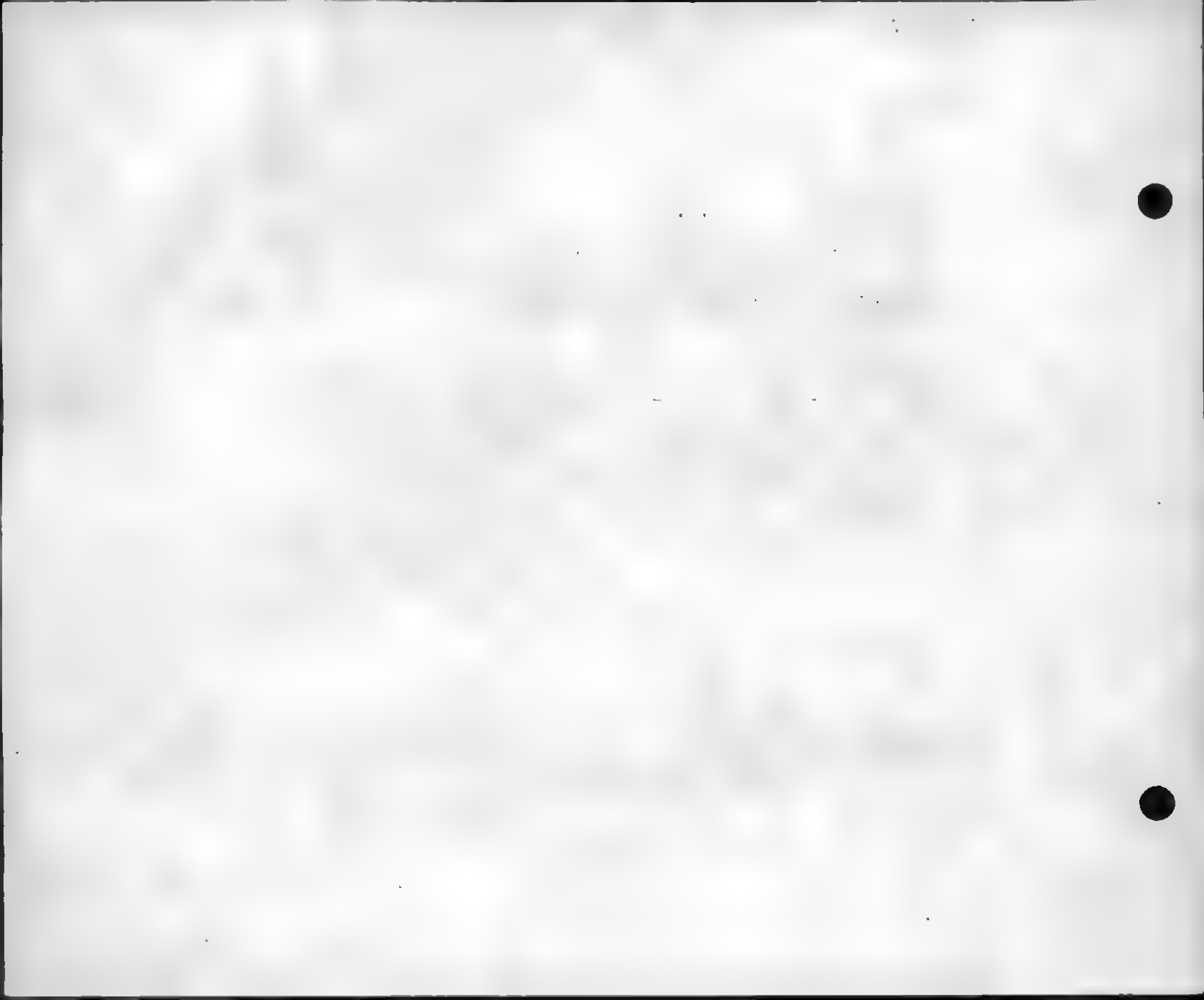
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06463

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06461

1. DECEASED NAME (Type or print) NELLIE MAY CORMACK			2a. DATE OF DEATH Month MAY Day 1 Year 1969			2b. HOUR 12:55 PM									
3. SEX F		4. RACE W		5. DATE OF BIRTH MAY 4 1905		6. AGE (In years last birthday) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 					
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.									
10. CITY OR TOWN OF DEATH Baltimore 21234			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8511 Oakleigh Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home						
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Balto 21234			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 8511 Oakleigh Road			
14. FATHER'S NAME First Harry Middle Riley Last 				15. MOTHER'S MAIDEN NAME First Honora Middle Staylor Last 											
16a. WAS DECEASED EVER IN U.S. ARMED SERVICES? Yes, na, or unknown) No (If yes give war or dates of service) ----				16b. SOCIAL SECURITY NO. 214-01-817-F2				17. INFORMANT Margaret Cormack				Address 			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST 4124 DUE TO, OR AS A CONSEQUENCE OF (Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.) (b) AFTER 8X LEPOTIC (ACQUA) WAR DISEASE 11 YRS. DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State 									
22a. I certify that (I) (this hospital) attended the deceased from JUNE , 19 65 , to MAY 1 , 19 69 , that (I) (we) last saw the deceased alive on FEB 6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Samuel A. O'honry MD						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED MAY 1 1969						
22d. PHYSICIAN'S NAME (Type) SAMUEL O'HONRY						22e. ADDRESS 2523 LECROUVEA RD 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE May 5, 1969			23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore County Maryland						
24. FUNERAL DIRECTOR William E. Johnson 8521 Loch Raven Blvd						25a. REC'D BY REGISTRAR MAY 5 1969			25b. REGISTRAR'S SIGNATURE William E. Johnson						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

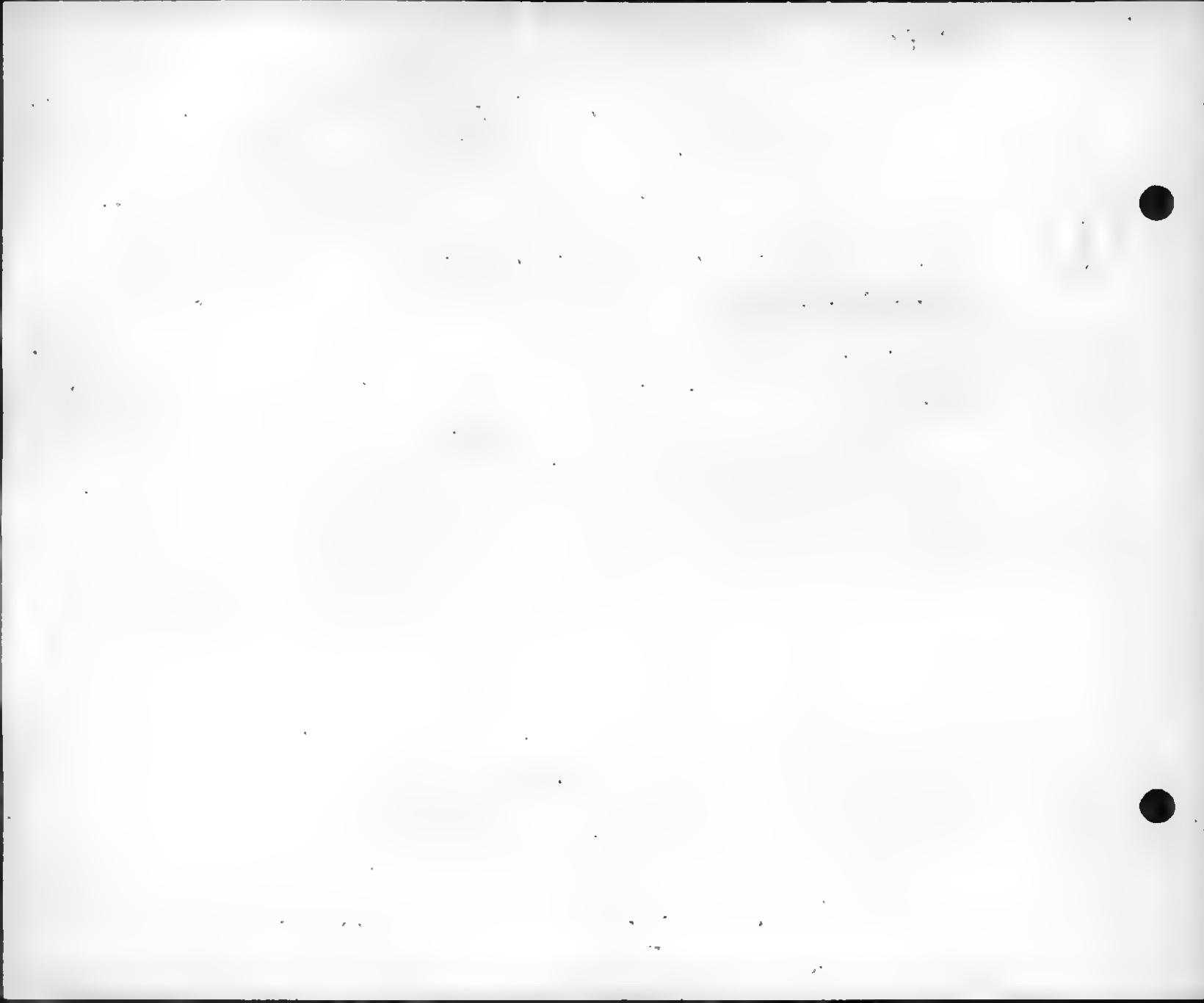
VR A13-70
30M REV 1-68

06464

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06462

1 DECEASED NAME (Type or print) ANNA AMELIA CREUTZER		First Middle Last		2a. DATE OF DEATH Month Day Year MAY 8 1969			2b. HOUR 2:10 PM	
3. SEX F		4. RACE W		5. DATE OF BIRTH AUG 3, 1880			6. AGE (in years last birthday) 88 YRS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Co.		
10. CITY OR TOWN OF DEATH TOWSON, MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Aged Home 615 CHESTNUT AVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALLS LADY			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD COUNTY BALTIMORE		13b. CITY OR TOWN TOWSON		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2715 STRATMORE		
14. FATHER'S NAME First Middle Last CHRISTIAN G CREUTZER		15. MOTHER'S MAIDEN NAME First Middle Last HENRIETTA LINCK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-14-5714		17. INFORMANT W. L. L. R. N. 615 Chestnut Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 1107 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden years								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Apr. 21, 1952 to May 8th, 1969 , that (I) (we) last saw the deceased alive on May 8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Newland E. Day MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED May 8, 1969		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 4-E-33rd St Balto Md.						
23a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL		23b. DATE 5-12-69		23c. NAME OF CEMETERY OR CREMATORY W. L. L. Cemetery		23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR Wm Cook-Brooks Towson, Inc		ADDRESS 1050 YORK RD Towson, Md. 21204		25a. REC'D BY REGISTRAR MAY 12 1969		25b. REGISTRAR'S SIGNATURE John J. Sledge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

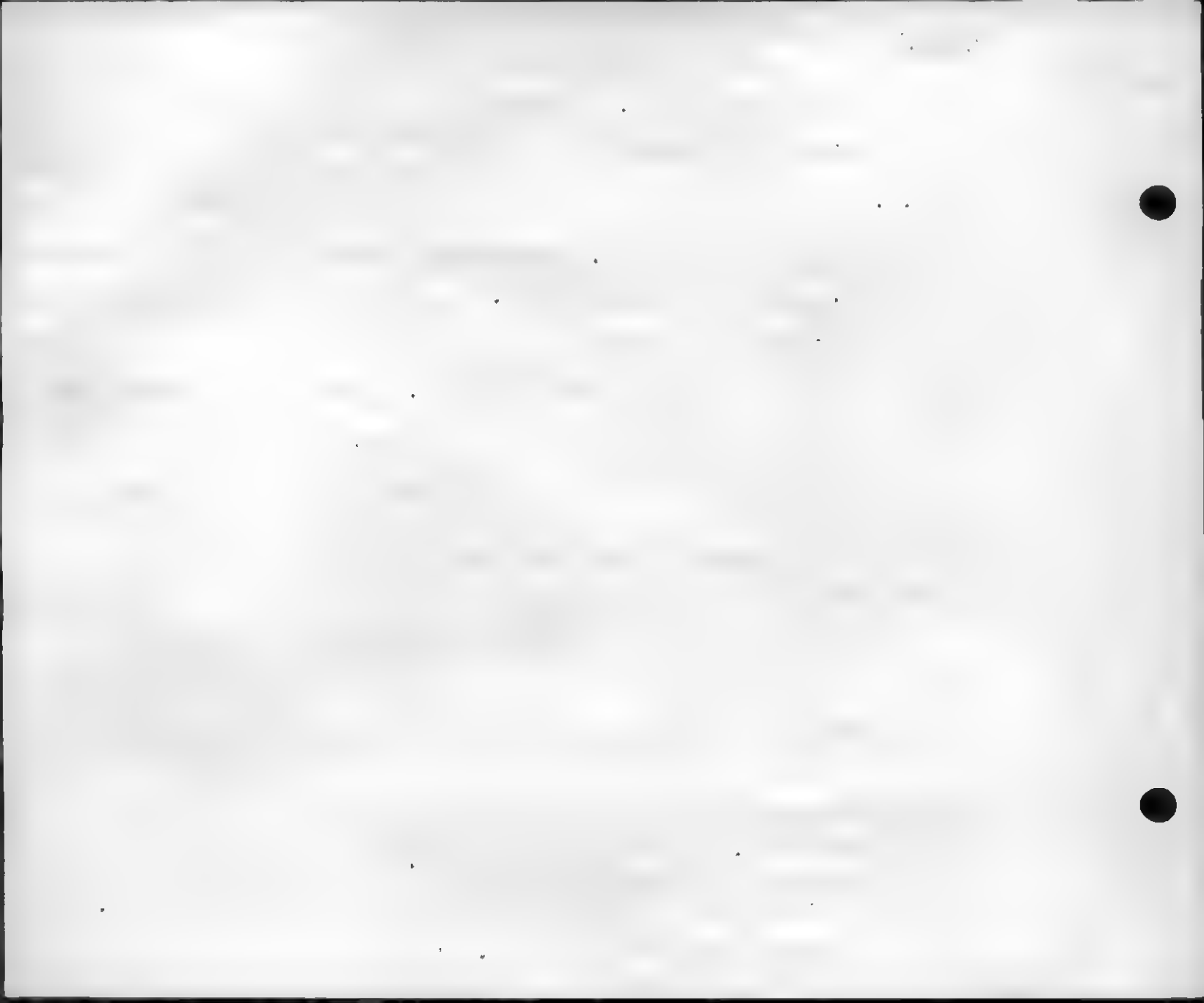
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06465

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06463

1 DECEASED-NAME (Type or Print) Elizabeth B. Cromwell			2a. DATE KNOWN OF DEATH EST. May 8 1969			2b. HOUR 12:30 PM		
3 SEX Female	4 RACE White	5 DATE OF BIRTH 11/29/1898	6 AGE (In years, last birthday) 70 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD May 8 1969		
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Md.			13b. COUNTY Baltimore Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 439 Evesham Ave		
14. FATHER'S NAME Herbert Varney			15. MOTHER'S MAIDEN NAME unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) NO			16b. SOCIAL SECURITY NO. 217 14 0422		17. INFORMANT Edwin B. Cromwell			
					ADDRESS 439 Evesham Ave			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Leukemia-lymphatic type DUE TO, OR AS A CONSEQUENCE OF (b) Fracture of left femur DUE TO, OR AS A CONSEQUENCE OF (c) 6 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION 3/31/69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture left femur			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 3/24/69 HOUR A.M. 9		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fall while in Home			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No Home		City or Town Baltimore		State Md.
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles F. O'Donnell			M.D. Charles F. O'Donnell			22b. DATE SIGNED 3/8/69		
EXAMINER'S NAME (Type) Charles F. O'Donnell			ADDRESS 7501 York Rd			22c. DEPT. MEDICAL EXAMINER Baltimore		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/12/69		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Balto. Md	
24. FUNERAL DIRECTOR Mitchell Wiedefeld Home				ADDRESS 6500 York Rd.		25a. REC'D BY REGISTRAR MAY 13 1969		25b. REGISTRAR'S SIGNATURE



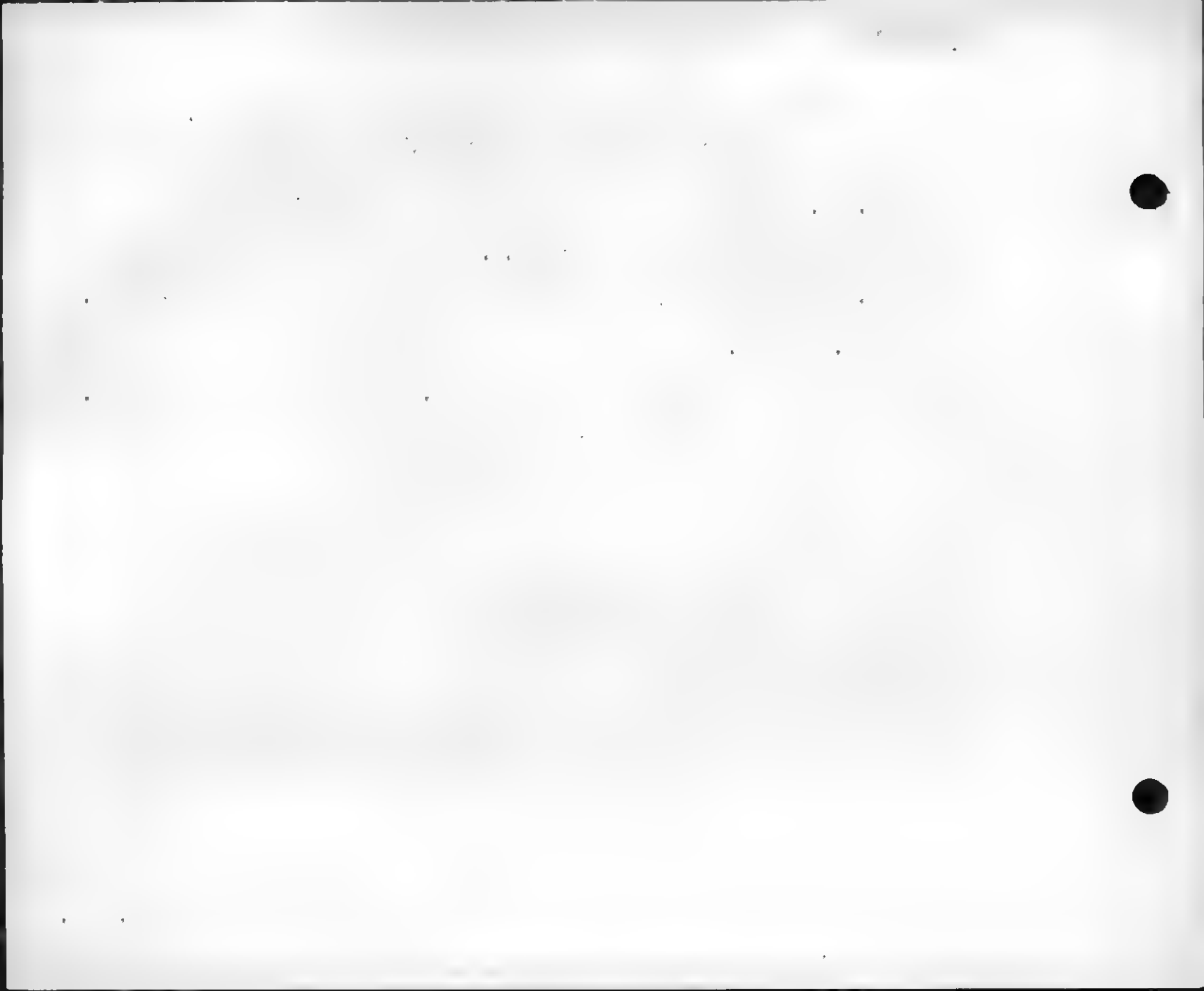
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13
30M REV 1-60

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED-NAME (Type or print)			First Ethel			Middle Hall			Last Crosby			2a. DATE OF DEATH Month 5 Day 4 Year 1969			2b. HOUR 11:50 A M		
3 SEX Female			4. RACE White			5. DATE OF BIRTH June 1, 1893			6. AGE (In years lost birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS _____ DAYS _____			IF UNDER 24 HRS. HOURS _____ MIN. _____		
7a. BIRTHPLACE (State or foreign country) Balto. Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md.					
10 CITY OR TOWN OF DEATH Anneslie			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Armacost N.H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) homemaker			12b. KIND OF BUSINESS OR INDUSTRY								
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Rodgers Forge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 205 Rodgers Forge Rd.					
4. FATHER'S NAME First Wm.			Middle H.			Last Hall			15 MOTHER'S MAIDEN NAME First Emma			Middle Askew					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 218 03 8454B			17 INFORMANT Lewis T. Crosby			Address 205 Rodgers Forge Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Secondary Anemia 1977 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____											
22a. I certify that (I) (this hospital) attended the deceased from Oct 12, 1968 to May 4, 1969 , that (I) (we) last saw the deceased alive on May 4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Laurence C. Post			22c. DATE SIGNED 5/5/69			22d. PHYSICIAN'S NAME (Type) LAURENCE C. POST			22e. ADDRESS 6805 Park Rd								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/7/69			23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Balto. Md.								
24. FUNERAL DIRECTOR Mitchell Wiedefeld			ADDRESS Home 6500 York Rd.			25a. REC'D BY REGISTRAR DATE MAY 6 1969			25b. REGISTRAR'S SIGNATURE John J. Judge								

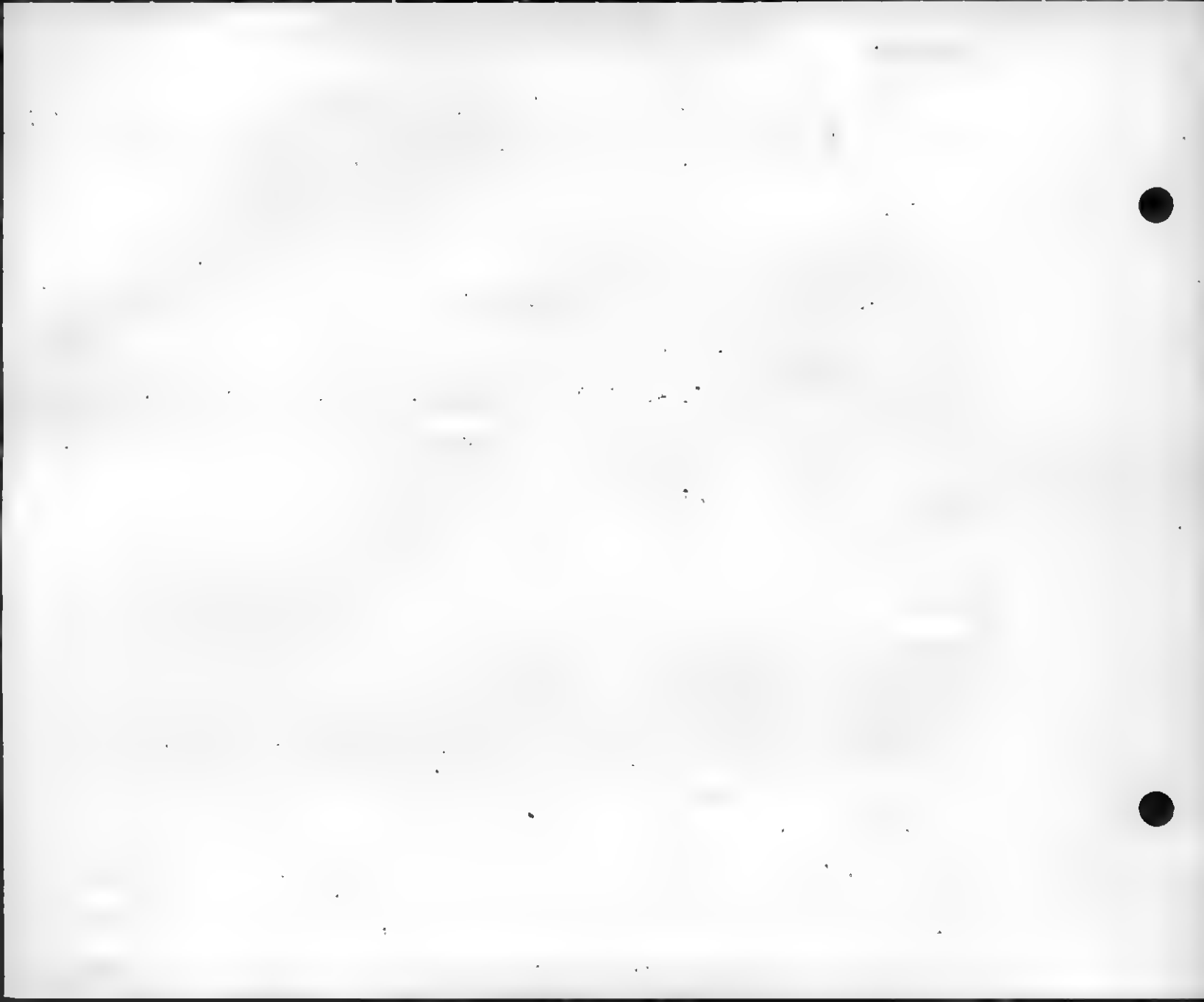
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) Benjamin Franklin Cullum						2a. DATE OF DEATH Month May Day 25 Year 1969			2b. HOUR 10:30 AM		
3 SEX male		4 RACE white		5 DATE OF BIRTH Oct. 14, 1890			6 AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS 7 DAYS 10		IF UNDER 24 HRS HOURS 30 MIN
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md.		
10 CITY OR TOWN OF DEATH White Marsh			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) --			12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired) Carpenter, Foreman			12b. KIND OF BUSINESS OR INDUSTRY US Govt. Ret.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN White Marsh		13d. INSIDE CITY (Y/N) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 175		
14 FATHER'S NAME First Albert Middle -- Last Cullum				15. MOTHER'S MAIDEN NAME First Mattie Middle -- Last Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO. 214-12-0311		17 INFORMANT Address Mrs. May M. Cullum, White Marsh, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 1124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD and CVA DUE TO, OR AS A CONSEQUENCE OF (c) --										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from July, 1967 , to May, 1969 , that (I) (we) last saw the deceased alive on May 25, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William A. Tyson						22c. ATTENDING PHYSICIAN DEGREE M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-25-69			
22d. PHYSICIAN'S NAME (Type) William A. Tyson						22e. ADDRESS Kingsville Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 28, 1969		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) Bel Air		County Harford		State Md.	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.						25a. REC'D BY REGISTRAR MAY 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH-DEPT.

10 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06468

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06466

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			Month	Day	Year	2b. HOUR
JEAN MARIE CUMMING						May 10, 1969					19	M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
female	white	Nov. 12, 1953	15 YRS.		MONTHS DAYS		HOURS MIN.		May 10, 1969		7:00 A.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
New York		U.S.A.				Baltimore Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Towson			St. Joseph's			Student			School			
13a. USUAL RESIDENCE (Where deceased lived, first full year of residence before death)			13b. CITY OR TOWN		13c. INSIDE CITY, IN 15?		13e. STREET AND NUMBER					
Maryland			Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		513 Hilltop Drive					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						
Donald S. Cumming			Dolores English			No (If yes give war or dates of service)						
16b. SOCIAL SECURITY NO			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
212-62-5085			Mr. Donald S. Cumming Same as # 13			PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cranio-Cerebral Injuries						
						DUE TO, OR AS A CONSEQUENCE OF (b)						
						DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			10:00 PM 5/9/ 19 69			passenger in car - struck a fence - thrown 300 feet.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
			street			Dulaney Valley Road, Baltimore, Maryland						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
Werner U. Spitz, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			5/10/69			
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, or other disposition			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)					
CREMATION			May 13, 1969		Green Mount Crematory		Baltimore, Maryland					
24. FUNERAL DIRECTOR			ADDRESS			25a. RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks Towson,			1050 York Road Towson, Maryland 21204			DATE MAY 12 1969						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

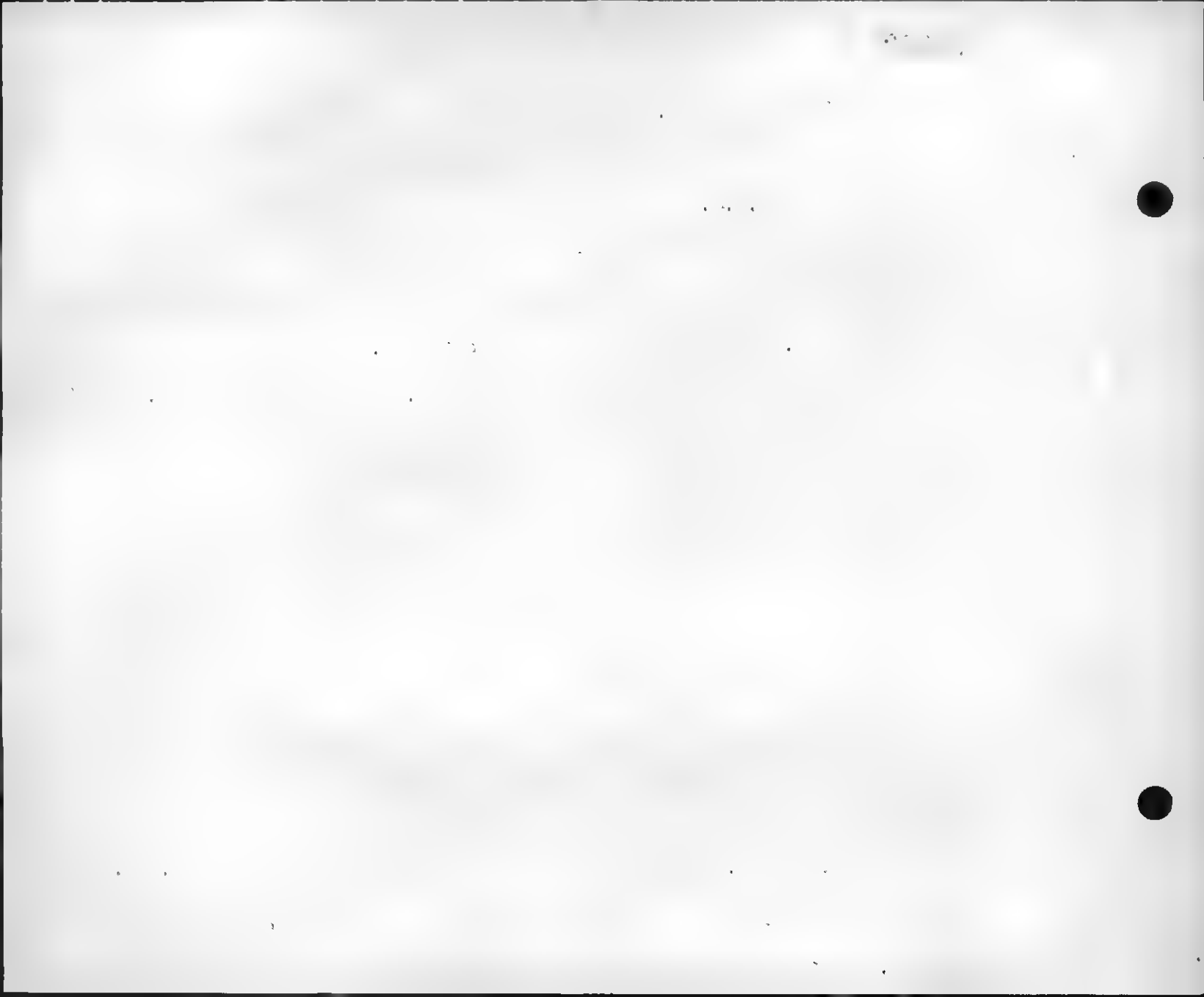
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

06469

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06467

1 DECEASED-NAME (Type or print) LESLIE			First O. Middle CURTIN Last			2a DATE OF DEATH Month May Day 17 , Year 1969			2b HOUR 6 55 A.M.		
3 SEX Male			4 RACE White			5. DATE OF BIRTH January 15, 1903			6 AGE (In years lost birthday) 66 YRS		
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore		
1d CITY OR TOWN OF DEATH Arbutus			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 943 Regina Drive			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired			12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Arbutus			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First James Middle H. Last Curtin			15. MOTHER'S MAIDEN NAME First Hattie Middle B. Last Colein								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO 214-01-4715			17 INFORMANT Address Mrs. Mary J. Curtin, 943 Regina Dr. 21227					
B CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of stomach with hepatic metastases 1517 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1968 to May 17, 1969 , that (I) (we) last saw the deceased alive on May 16 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE John Nesbitt			22c DATE SIGNED 5-17-69			22d PHYSICIAN'S NAME (Type) Dr. John A. Nesbitt					
22e ADDRESS 1009 Frederick Road, Balto., Md. 21228											
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 5-20-1969			23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d LOCATION (City or Town) (County) (State) Baltimore, Maryland 21229		
24 FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			25a REC'D BY REG STRAR MAY 19 1969			25b REGISTRAR'S SIGNATURE Howard H. Hubbard					

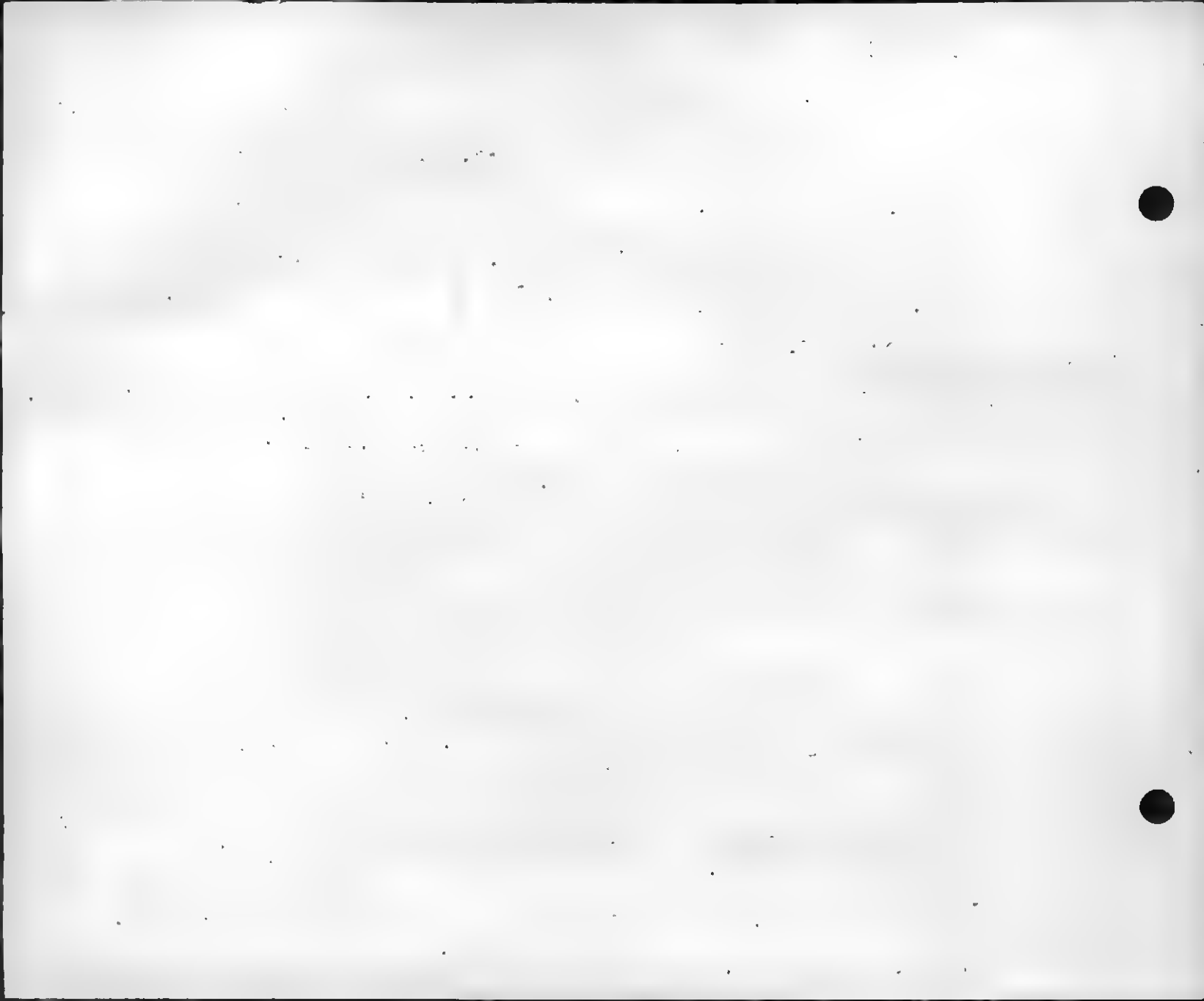


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

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30M REV. 1/68

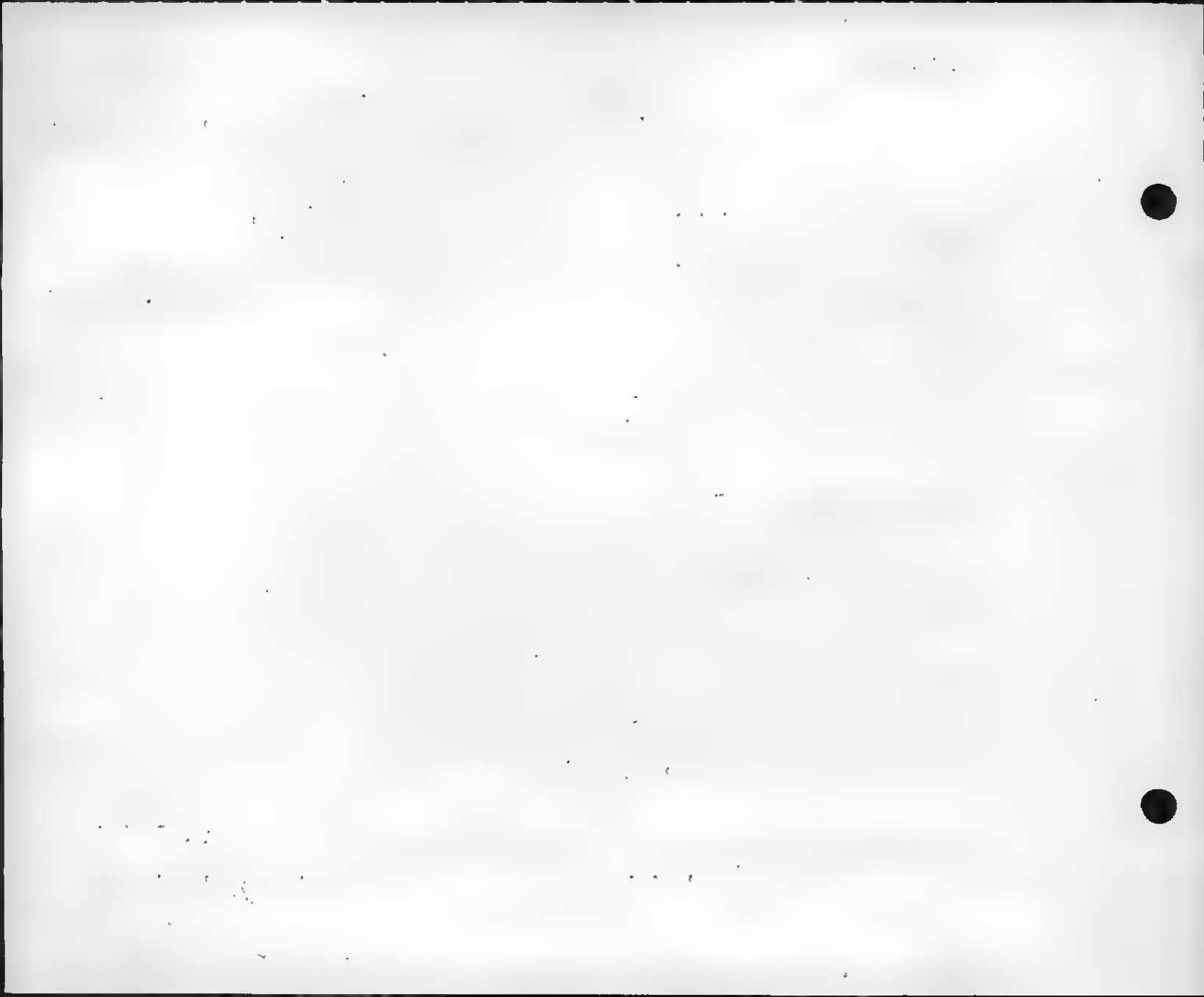
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
HELEN GERTRUDE DAMEREL						Month 15, Day 1969		10:30 A.M.	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
F		W		Dec. 2, 1878		90 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				Baltimore			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore City		Armacost N.H. 812 Register Ave.		Housewife		Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY, LIM TS?		13e. STREET AND NUMBER	
Md.		Baltimore		Nr. Balto		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		44 Acorn Circle	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George T. Smith			Rebecca Lawson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
No		215 50 0688		J1 Mrs. A. V. Nordling 44 Acorn Circ.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebral Vascular Accident									
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		City or Town		County State	
				Street or R.F.D. No.					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on May 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Laurence C. Post		5/16/69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
LAURENCE C. POST		6805 York Rd							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		5/18/69		Deal Island		Deal Island, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOHN F. DENNY, INC.		715 Light St.		Balto., Md.		MAY 20 1969			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print)		First		Middle		Last		SR		2a. DATE OF DEATH Month Day Year		2b. HOUR	
		JOHN		WILLIAM		DEBELIUS				MAY 18, 1969		11:05 P	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
MALE		WHITE		FEBRUARY 13, 1903		66 YRS.		MARYLAND		U.S.A.			
9. COUNTY OF DEATH		10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE, Md		TOWSON		ST. JOSEPH HOSPITAL		Secy.		Imperial Marine					
13a. USUAL RESIDENCE (Where deceased lived, if institution adm ssion)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		13f. CITY AND STATE			
MARYLAND				BALTIMORE				2700 PELHAM AVE.		BALTIMORE, Md		#21215	
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle Last	
		John		W.		Debelius				Ida E.		Duval	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address							
no		215-09-2957		Catherine Miller Debelius, wife, above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral hemorrhage													
DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Myocardial infarction													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cal examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
		HOUR A.M. Month Day Year											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (X) (this hospital) attended the deceased from May 18, 1969 to May 18, 1969 , that (I) (we) lost saw the deceased alive on May 18, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED							
						5-19-69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
Ines Cilliani, M.D.		7620 York Road, Towson, Md. 21204											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		5/22/69		Holy Redeemer Cem.		Baltimore, Md.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Schmiedel Funeral Home		3321 Johns		MAY 21 1969		Charles Judge							

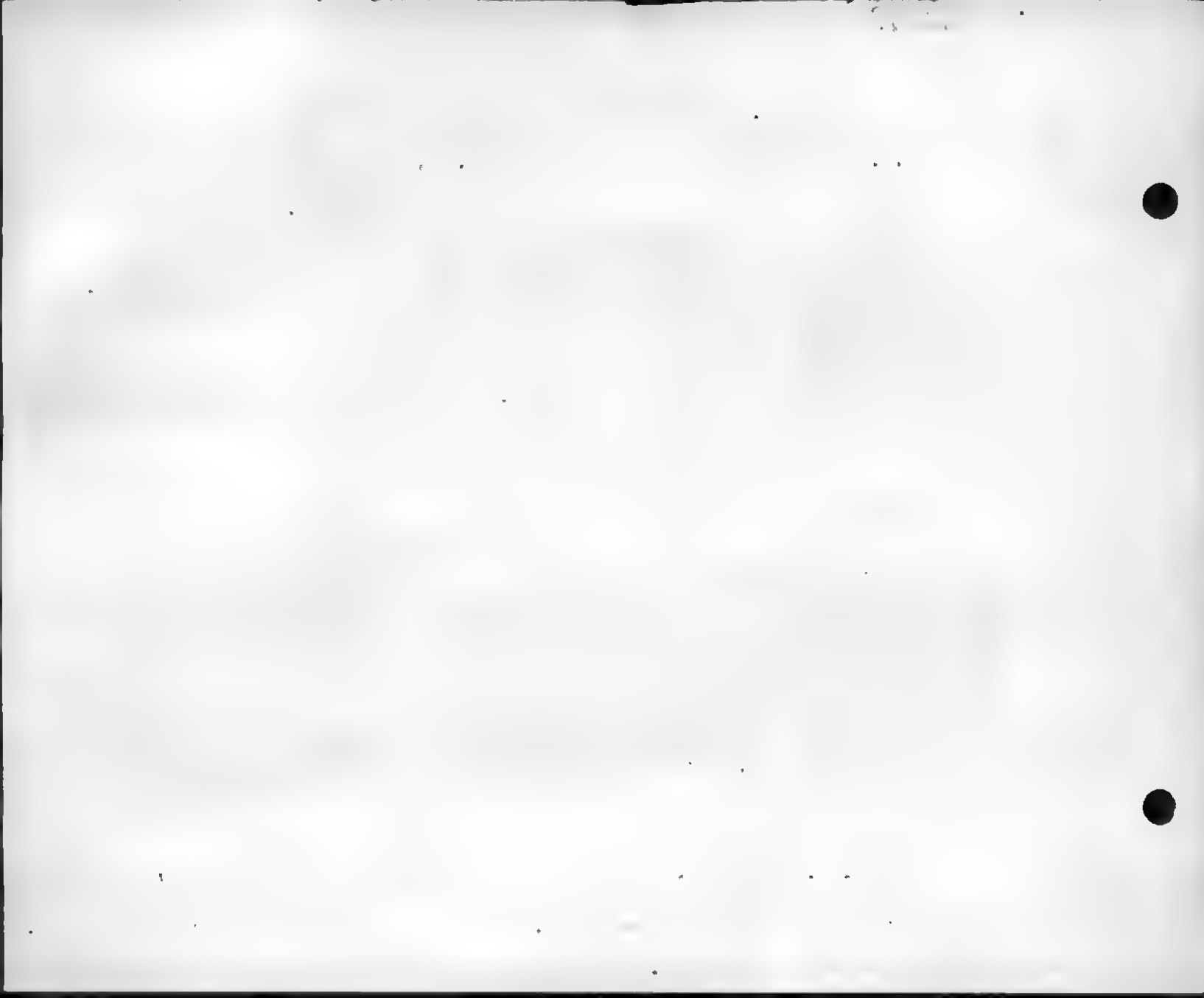


4124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

<div>06472</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 13 Film 412 5/23/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>06470</div>														
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR			
Margaret D. DeFord									May 15 1969		3:30 A M			
3. SEX		4 RACE		5 DATE OF BIRTH				6 AGE (in years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS		
F.M.		White		Feb. 14, 1886				83 YRS.		MONTHS		DAYS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH								
Balto; Md		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto. Co								
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY								
Randallstown		Chapel Hill Nursing Home		housewife										
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d IN STATE CITY LIMITS?		13e STREET AND NUMBER						
Md		Balto		Randallstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Liberty & Robson Rd. 8907 Flagstone Circle						
14 FATHER'S NAME			First			Middle			Last			15. MOTHER'S M A D E N NAME First		
William			Edward			Doughty			Virginia			Fisher		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address town, 21133					
no			215 48 4005			Mrs. Gene Dague, 8907 Flagstone Ct; Randalls								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY.														
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT										72 HRS.				
DUE TO, OR AS A CONSEQUENCE OF														
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)										15 YRS.				
(b) ASCVD														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)														
CARCINOMA UTERUS.														
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year												
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory)		21f LOCATION Street or RFD No		City or Town		County		State				
While <input type="checkbox"/> Not while <input type="checkbox"/>		(Office building, etc)												
at work <input type="checkbox"/> at work <input type="checkbox"/>														
22a. I certify that (I) (this hospital) attended the deceased from May 1968, to 5-15, 1969, that (I) (we) last saw the deceased alive on 5-15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (d not) view the body after death														
22b SIGNATURE		DEGREE		ATTENDING PHYS		MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED						
R. V. Houck, Jr.								5-15-69.						
22d PHYSICIAN'S NAME (Type)		22e ADDRESS												
R. V. Houck, Jr.		Liberty Rd; Eldersburg, Md.												
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)				
burial		5 17 1969		Loudon Pk.		Fredrick Ave; Balto				Md.				
24. FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE								
Loring Byers 8728 Liberty Rd. Randallstown				MAY 19 1969		Charles Judge								



1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

06473

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06471

1. DECEASED-NAME (Type or print) Charles Edward Dertz			2a. DATE OF DEATH Month 5 Day 30 Year 69			2b. HOUR 8:30 AM				
3 SEX M		4 RACE W		5 DATE OF BIRTH 10/16/03		6 AGE (In years last birthday) 65 YRS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9 COUNTY OF DEATH Balto				
10. CITY OR TOWN OF DEATH Balto County			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7607 Inwood Ave			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Crane Operator			12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Balto		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS? 7607 Inwood Ave			
14 FATHER'S NAME First Charles Middle Dertz Last Dertz				15. MOTHER'S MAIDEN NAME First Mamie Middle STump Last STump						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 705-16-7106		17 INFORMANT Wife				Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 5/30 , 19 69 , to 7/30 , 19 69 , that (I) (we) last saw the deceased alive on 5/30 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Arthur A Serpick MD						22c. DATE SIGNED 5/30/69		22d. PHYSICIAN'S NAME (Type) Arthur A Serpick		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE June 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cemetery			23d. LOCATION (City or Town) (County) (State) Howard, Maryland		
24. FUNERAL DIRECTOR Loring Byers Chapel			ADDRESS 8728 Liberty Road 21133			25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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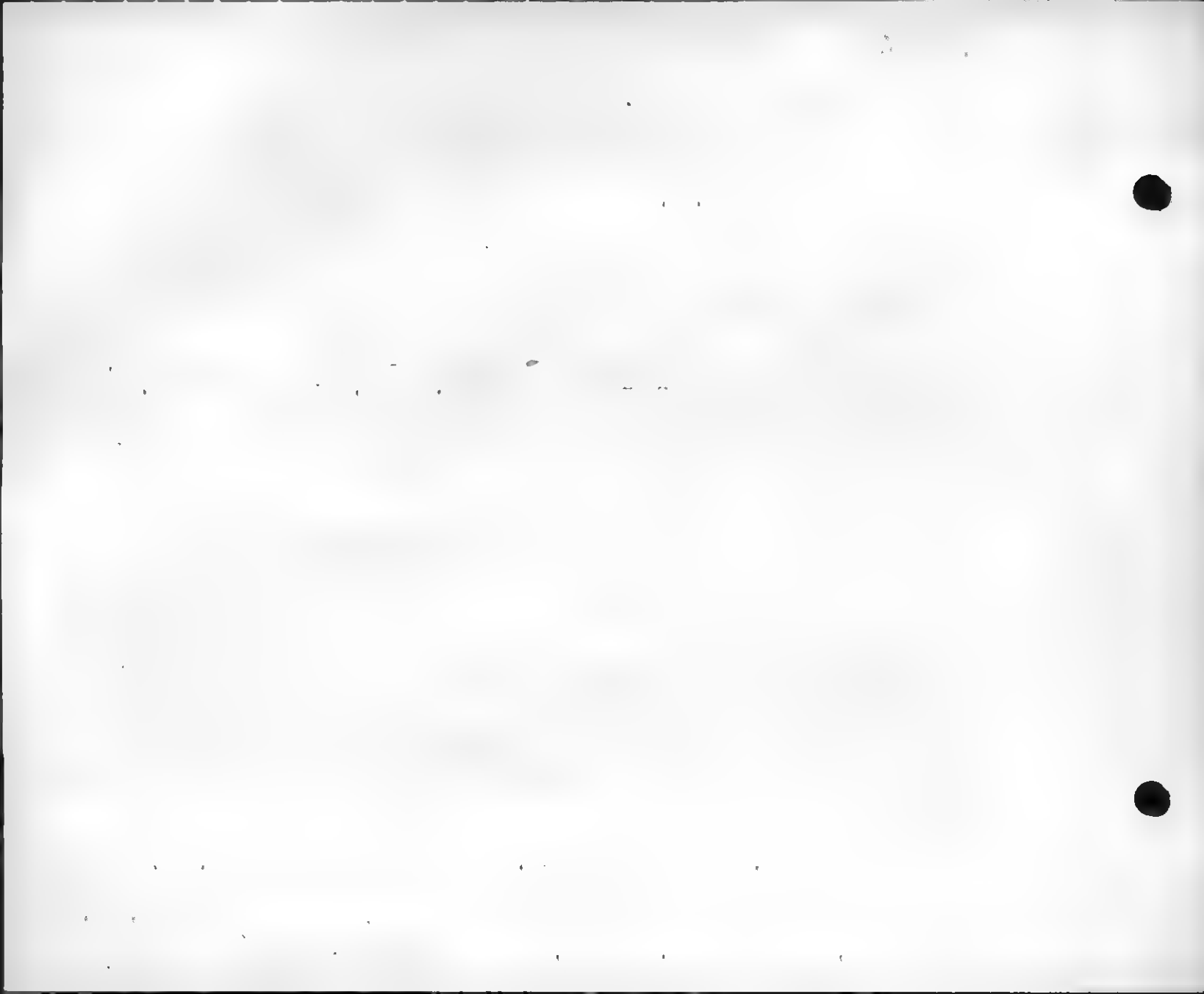
06474

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06472

1. DECEASED-NAME (Type or print) Julia		First Julia	Middle M.	Last DeLuca	2a. DATE OF DEATH Month May Day 19 Year 1969		2b. HOUR M		
3 SEX Female		4. RACE White		5. DATE OF BIRTH 11/23/00		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2447 Fairway	
14. FATHER'S NAME First Michael Middle Last Litrenta		15. MOTHER'S MAIDEN NAME First Philomena Middle Last Porco							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 215-16-0564D		17. INFORMANT Son-in-law Address Dundalk, Md. George R. Lucas, 1902 Stanhope Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular 1341 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia									
19a. DATE OF OPERATION 1967		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebral Vascular		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State 					
22a. I certify that (I) (this hospital) attended the deceased from April 27 1969 , to May 20 1969 , that (I) (we) lost the deceased alive on May 13 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.									
22b. SIGNATURE Sylvan D. Goldberg		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/20/69					
22d. PHYSICIAN'S NAME (Type) Sylvan D. Goldberg		M.D. 		22e. ADDRESS Medical Arts Bldg. Balto. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/23/69		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS 		25a. REC'D BY REGISTRAR DATE MAY 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

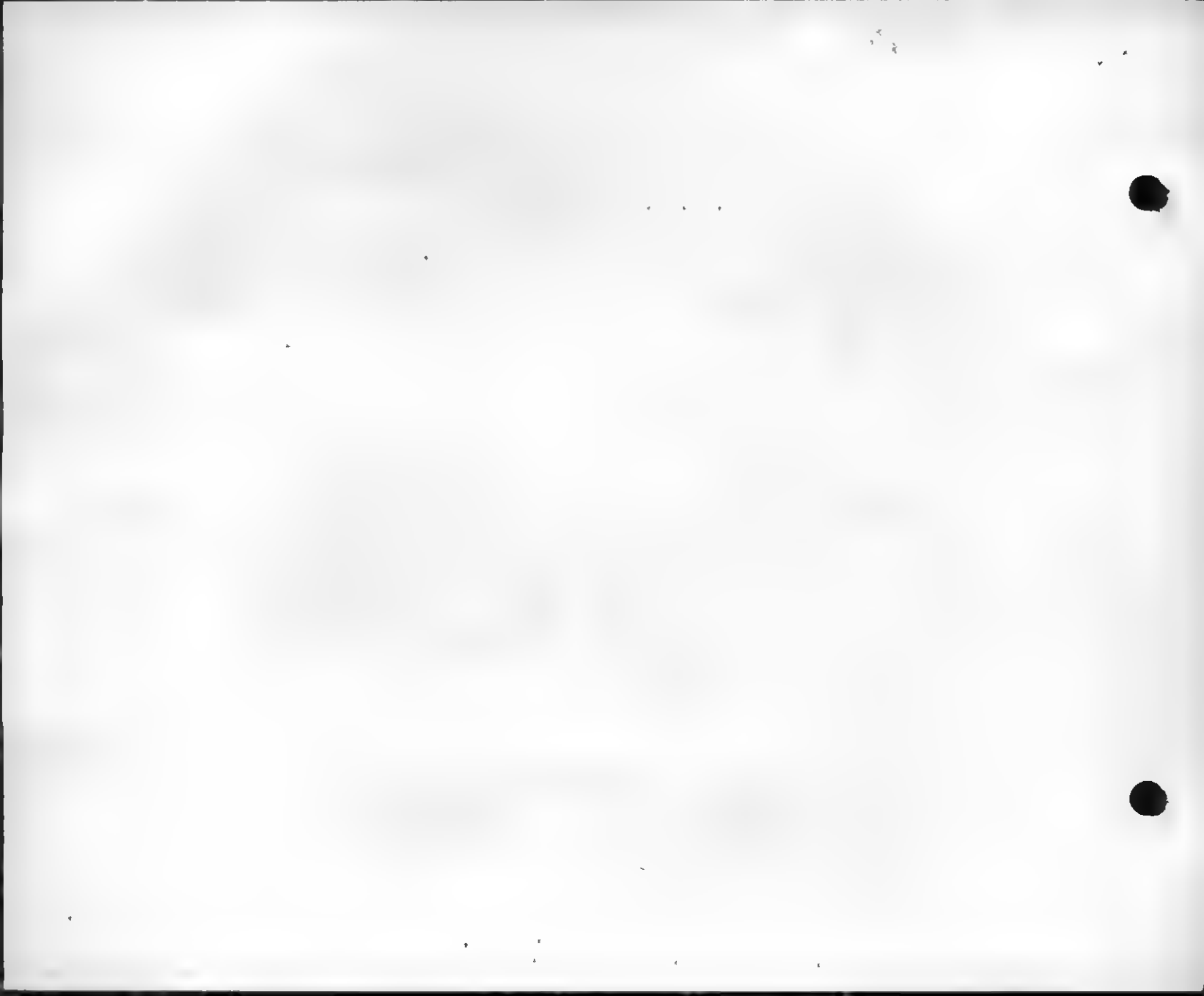
06475

06473 7³⁰ PM

1. DECEASED-NAME (Type or print) First Middle Last Cora Lee Dennison			2a. DATE OF DEATH Month Day Year 5 9 1969			2b. HOUR 7:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 01/15/84		6. AGE (In years last birthday) 85 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7366 Woodbury Road		14. FATHER'S NAME First Middle Last Samuel Thompson		15. MOTHER'S MAIDEN NAME First Middle Last Mary Tadgett		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 212-56-0506		17. INFORMANT Records--Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>year</u> <u>year</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Moderate advanced pulmonary tuberculosis inactive</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <u>1/27/69</u> , 19 <u>69</u> , to <u>5-9</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>5-9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Juan A. Perez-Balboa</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5-9-69</u>	
22d. PHYSICIAN'S NAME (Type) JUAN A. PEREZ-BALBOA				22e. ADDRESS Spring Grove State Hospital			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE May 12-69		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg Md.	
24. FUNERAL DIRECTOR Simmons Bros. 1661- Gd. Hope				ADDRESS RD. Wash. SE. DC		25a. REC'D BY REGISTRAR MAY 12 1969	
				25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06476					06474				
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b. HOUR
Walter Lee Dill						May 13 1969			10:55 AM
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Aug. 1, 1909		59 YRS.			
7a BIRTHPLACE (State or foreign (country))		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
North Carolina		U.S.A.				Baltimore Co., Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Owings Mills			6 Wengate Court			Pipe Fitter-Steel		Industry	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
Maryland			Baltimore		Owings Mills				6 Wengate Court
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
John Ramsey Dill			Callie Elizabeth Pressley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT				
No			251-01-7016		Mrs. Etna Dill 6 Wengate Court Owings Mills, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rectum</u>									months
1541 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 11, 1969</u> , to <u>May 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>5-11-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>David J. Miller</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>5-13-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>David J. Miller</u>						22e. ADDRESS <u>2115 Eastwood Ave. Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 17, 1969		Lake View Mem. Gardens		Sykesville, Carroll, Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
H. J. Schaubert				Owings Mills, Md.		MAY 16 1969			

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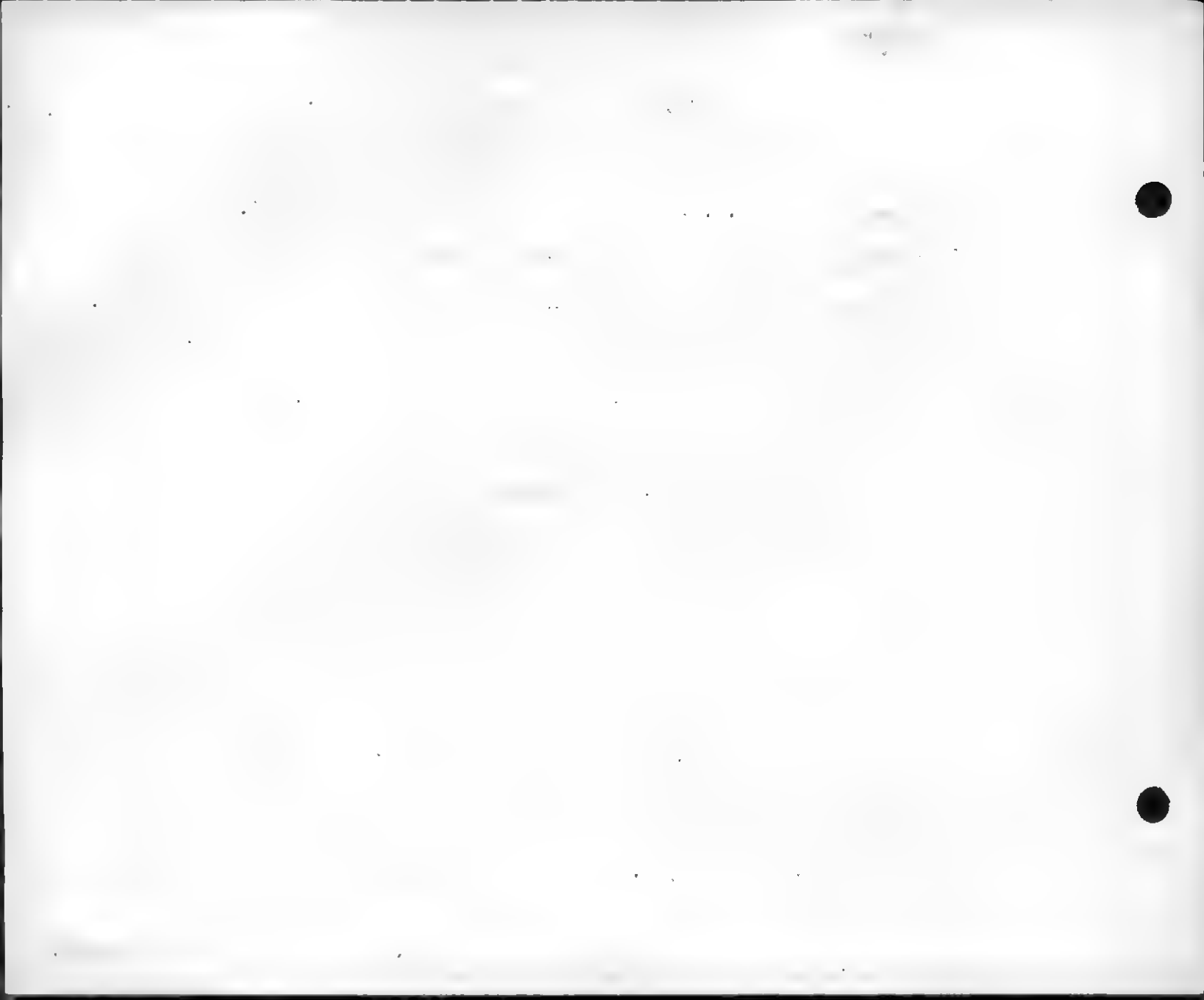
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

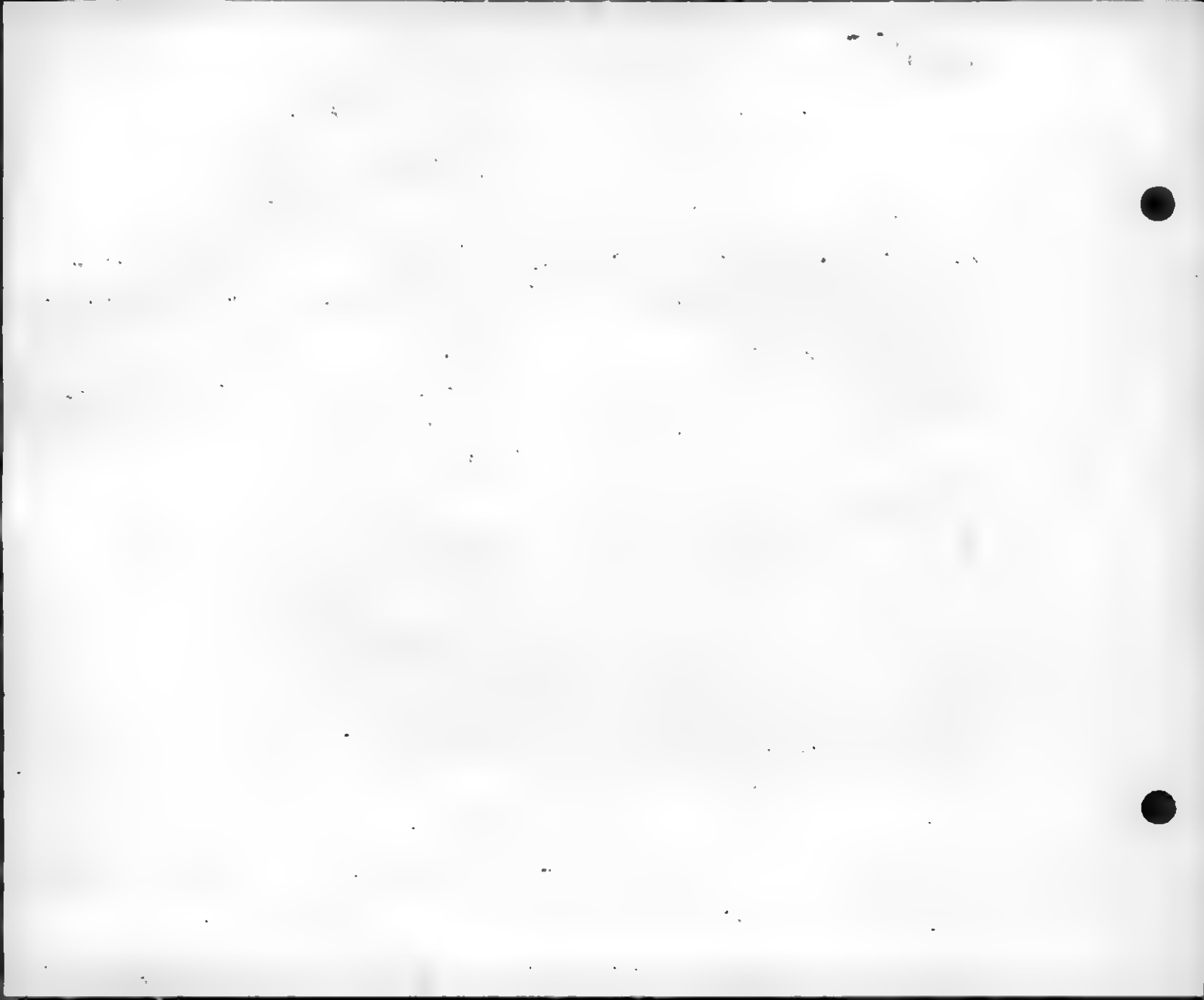
06477		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06475	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR YRS.
LOUIS RICHARD DI STEFANO		LOUIS	RICHARD	DI STEFANO	MAY 23 1969		9:25PM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	
Male	White		1/22/10		59		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY
Maryland	U.S.A.				BALTIMORE		Trucking
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Fort Howard		Veterans Administration Hospital		Truck Driver			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland				Baltimore	YES	1154 Washington Blvd. (21230)	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Louis B. DiStefano		Bessie		Hofner WERNER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		7. INFORMANT Address			
Yes		WWII		218 09 3350 VAH, Fort Howard, Maryland			
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEPATIC COMA							DAYS
571.9 DUE TO, OR AS A CONSEQUENCE OF							YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) LIVER CIRRHOSIS							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (this hospital) attended the deceased from 5/23/1969, to 5/23/69, 19, that (I) (we) last saw the deceased alive on 5/23/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE Pushpendra Senan M.D. DEGREE				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/24/69	
22d. PHYSICIAN'S NAME (Type) PUSHPENDRA SENAN, M.D.				22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5/27/1969		Baltimore National Cem.		Baltimore, Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Cowan Funeral Home		Hollins & Poppleton Baltimore, Maryland		DATE MAY 26 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR						
JOHN R. DIX						MAY 21 1969			M						
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
M		W		10/23/97			71 YRS		MONTHS DAYS		HOURS MIN				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.			
VA.			USA						BALTO						
1d. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
BOWLEYS QUATERS				COLD SPRING RD BOX 284								BRICK			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
MD.				BALTO		BOWLEYS QUATERS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		COLD SPRING RD BOX 284					
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last									
JOHN W. DIX						ARINTHA TAYLOR									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)						16b. SOCIAL SECURITY NO		17. INFORMANT Address							
UNK						2:4-14-3054		IRA TAYLOR 7709 BLUEGRASS RD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Carcinoma prostate															
185X DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from March 19 63 to May 21 19 69, that (I) (we) last saw the deceased alive on May 21 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE								22c. DATE SIGNED							
LOUIS SEMENOFF MD								5/22/69							
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS							
LOUIS SEMENOFF								2108 CREMS RD BALTO MD 21220							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
REMOVAL				5/24/69		DOWNINGS		NEW CHURCH VA.							
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
J.G. CONNELLY SONS						300 MACE		MAY 26 1969		Charles Judge					



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

06479

06477

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Bentley			First Middle Last T. Dixon Sr.			2a DATE KNOWN OF DEATH ESTI MATED 5-14-1969 17 M			2b HOUR			
3 SEX Male	4 RACE White	5 DATE OF BIRTH 1/17/14	6 AGE (In years last birthday) 55 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Year 1969 11 M			2d HOUR	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md						
10 CITY OR TOWN OF DEATH Dundalk		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3916 Old North Pt. Road				12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic - North Point Steel Co.			2b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived 6 months or more) Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 3916 Old North Pt. Road				
14 FATHER'S NAME Bentley			First Middle Last C. Dixon			15 MOTHER'S MAIDEN NAME Myra M. Luhn			First Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b SOCIAL SECURITY NO (If yes, give war or dates of service) 212-12-4681			17 INFORMANT (Brother) Mr. Leslie H. Dixon, 4302 White Ave.			ADDRESS Balto. Md. 21206			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>H-S-C-V-DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Alcoholism</u>												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State			
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Melvin B. Davis			M.D. M. D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED 5/14/69 6000 Mornington Rd. ADDRESS (Street, city, town, or county) Dundalk, Md. 21222			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 5/19/69			23c NAME OF CEMETERY OR CREMATORY Baltimore National Cem.			23d LOCATION (City or Town) (County) (State) Baltimore, Md.			
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						25a REC'D BY REGISTRAR DATE MAY 19 1969			25b REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or at a burial, cremation, or removal, and in any event, within 72 hours after death.

1

06480

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06478

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P	
Thomas		E		Dolan, Sr.	May 7 1969		6:35 M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
male	white		May 28, 1892		76 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Penna. U.S.A.		U.S.A.				Baltimore Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		Dulaney Towson Nursing Home		general foreman		steel co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Baltimore		Lutherville		YES		514 Hilltop Drive
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Patrick Joseph Dolan		Julia McGovern Dolan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no		213-07-0029		Dulaney Towson Nursing Home, 111 West Road 21204				
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>1123</u> DUE TO, OR AS A CONSEQUENCE OF <u>ARTERIO-SCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>5-7-1969</u> , to <u>5-7-1969</u> , that (I) (we) last saw the deceased alive on <u>5-7-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
K.A. Manley		5-8-69						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
K.A. MANLEY								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5-10-1969		Holy Redeemer Cemetery		Baltimore, Maryland		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks Towson		1050 York Road 21204		DATE MAY 9 1969		Charles Jones		

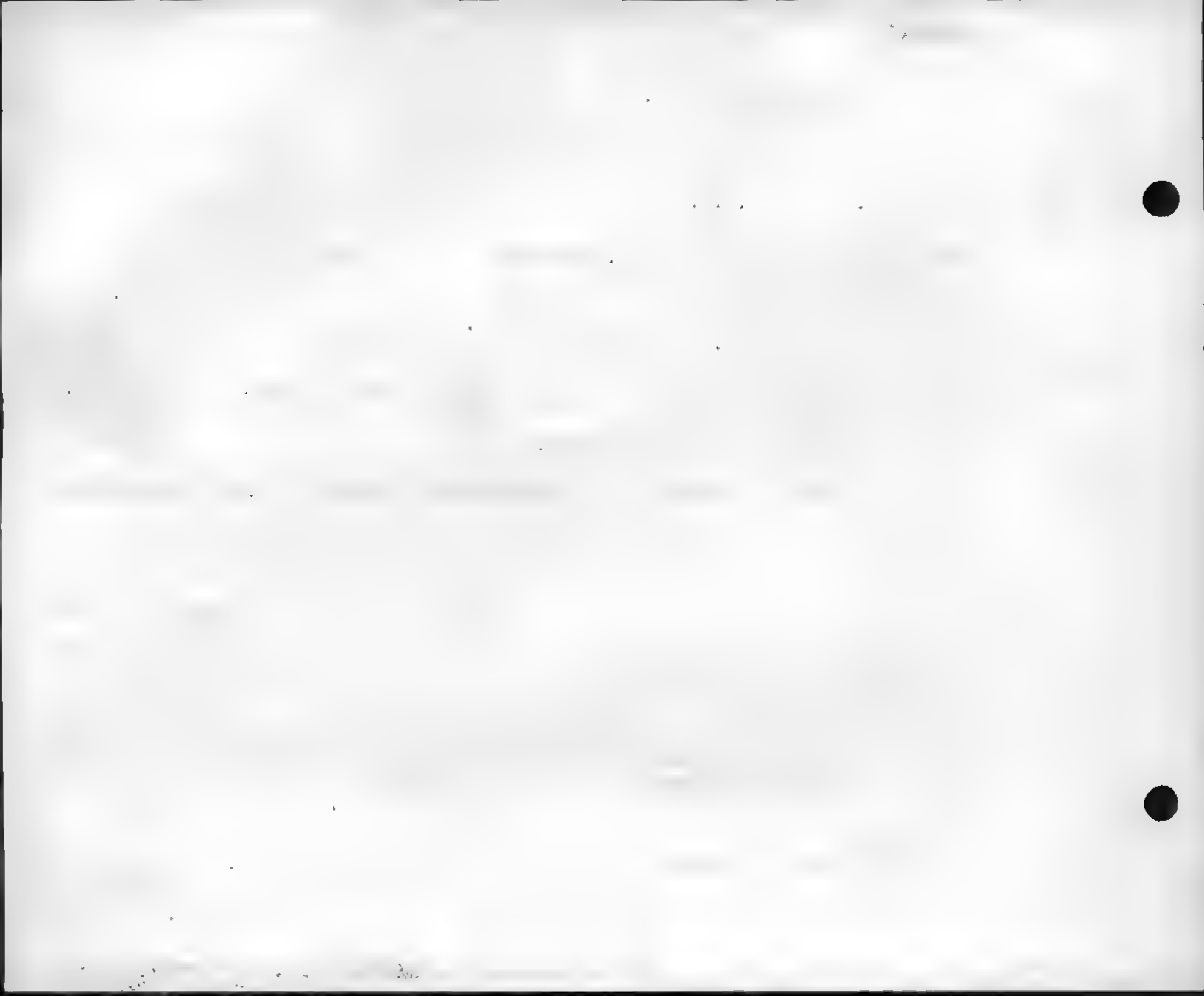


1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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06481		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06479	
Item 23 Film 413 5/29/69 kk					
1 DECEASED-NAME (Type or print)		First Middle Last WILLIAM J. DOOLING		2a. DATE OF DEATH Month Day Year 5 21 69	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 10/7/17	
7a BIRTHPLACE (State or foreign country) BALTO. MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (In years last birthday) 51 YRS	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY Md			
10 CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PLUMBER	
12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY		13c CITY OR TOWN BALTIMORE	
13d INSIDE CITY, LAKE? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 831 N. MILTON AVE.			
14 FATHER'S NAME First Middle Last FRANK C. DOOLING		15 MOTHER'S MAIDEN NAME First Middle Last ELLEN KELLY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b SOCIAL SECURITY NO 218 03 37 36		17. INFORMANT Address CLIN. RECORDS, VA HOSP. FT HOWARD, MD.	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 1021 DUE TO, OR AS A CONSEQUENCE OF (Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.) (b) BRONCHOGENIC CARCINOMA RIGHT LUNG WITH WIDESPREAD METASTASES DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (a) (this hospital) attended the deceased from 1/27/69, 19__, to 5/21/69, 19__, that (i) (we) last saw the deceased alive on 5/21/69, 19__, and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.					
22b SIGNATURE Erhard J. Bunyor M.D.				22c DATE SIGNED 5/21/69	
22d. PHYSICIAN'S NAME (Type) ERHARD J. BUNYOR, M. D.				22e ADDRESS VAH FORT HOWARD, MD.	
23a BURIAL, CREMATION, REBURY (Type)		23b DATE 5/23/1969		23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATL.	
23d LOCATION (City or Town) (County) (State) BALTIMORE, MD.					
24. FUNERAL DIRECTOR		ADDRESS JOSEPH N. ZANNINO FUNERAL HOME 257 S. Conkling St.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	

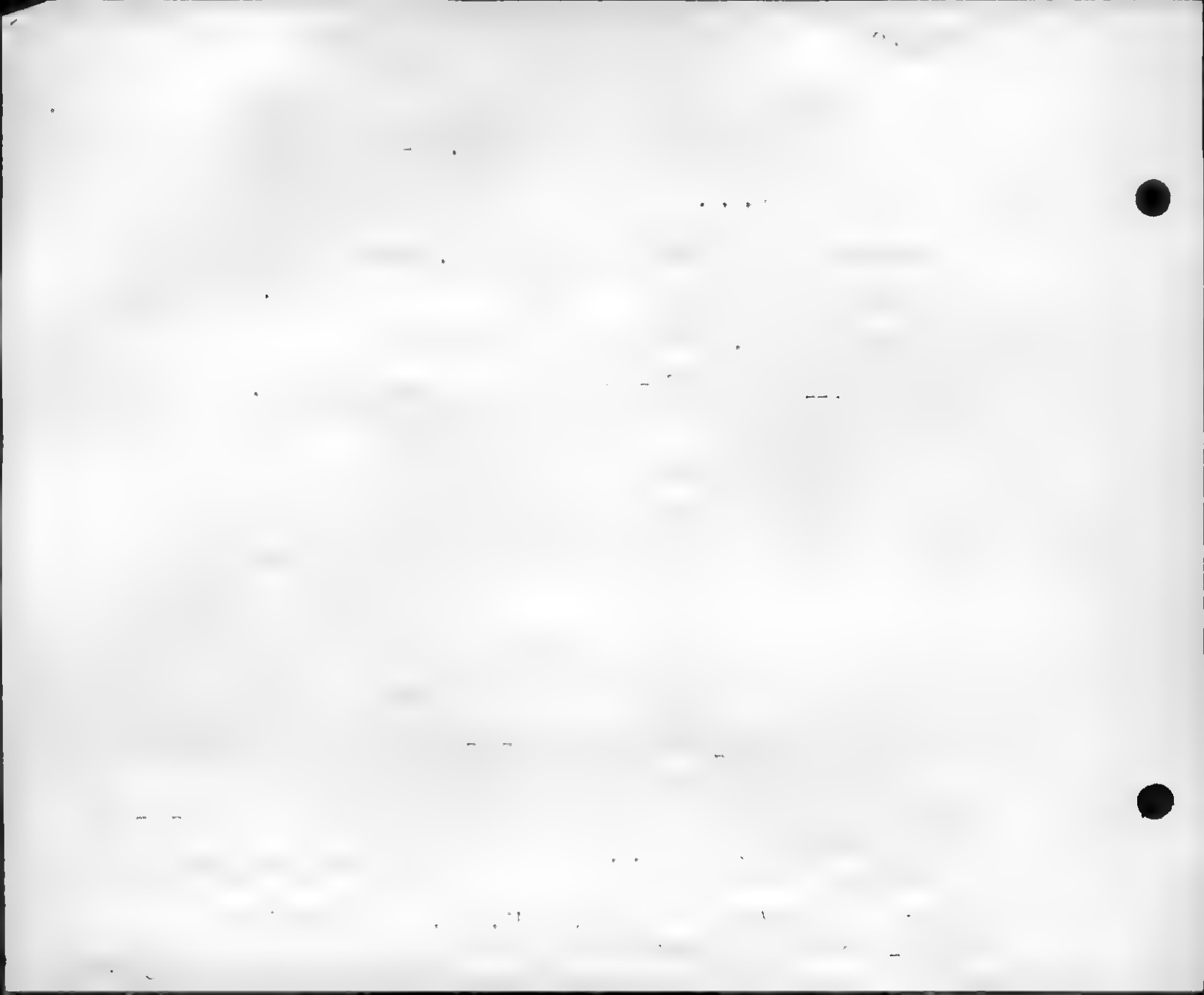


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

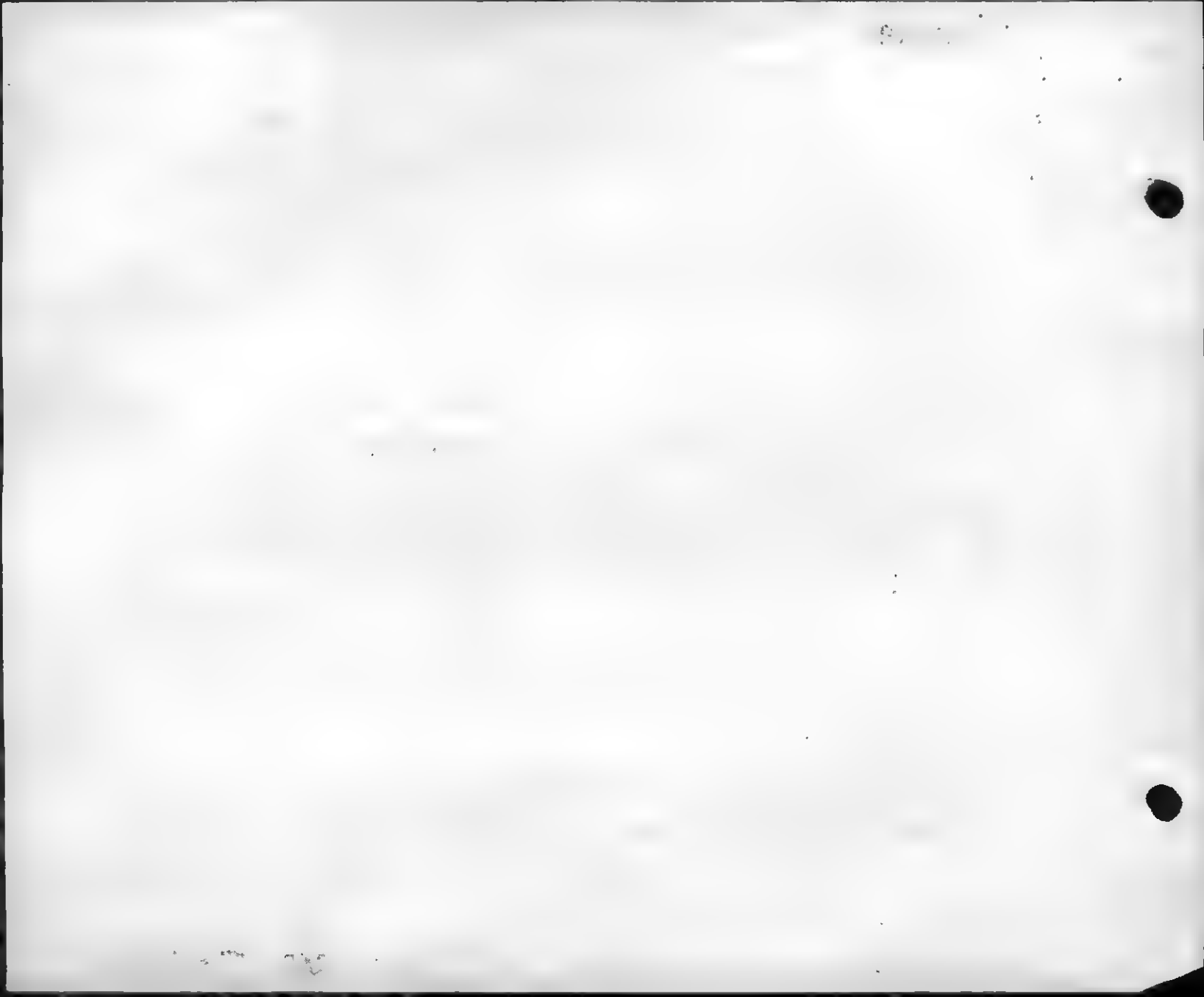
VR 45M (4) 1/69

06482		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06480		
1. DECEASED-NAME (Type or print) LILLIAN		First V	Middle DUBART	Last		20. DATE OF DEATH 5 Month 21 Day 1969		2b. HOUR 10.30 M
3 SEX Female	4 RACE White		5. DATE OF BIRTH 2. 2 -91		6. AGE (In years lost birthday) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.M.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Spring Grove State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Practical nurse		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 440 S. Gilmore
14. FATHER'S NAME Samuel L. McCready		First Middle Last		15. MOTHER'S MAIDEN NAME Sarah McCall		First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 218-05-3 446		17. INFORMANT Hospital record.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A. S. C. V. D. 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Decubitus ulcers, Uremia.								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased on 20-21-63 , 19 63 , at 5-21 , 19 69 , that (I) (we) last saw the deceased alive on 5-21 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Vicente M. Ruano M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-21-1969		
22d. PHYSICIAN'S NAME (Type) VICENTE M. RUANO M.D.		22e. ADDRESS Spring Grove State Hospital						
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial		23b. DATE 5/26/69		23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore		
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, 6500 York Rd. 21212		ADDRESS		25a. RECD BY REGISTRAR MAY 28 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



OK William M. D. Deputy Medical Examiner, Baltimore, Md. to HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Elizabeth K		K		K		K		Month Day Year May 18 1969		4:30 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		7 UNDER 24 HRS	
female		white		1/6/88		58 8 1/2 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARR ED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Balto md		US				Balto Co.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Towson md		Chesapeake Manor		Housewife							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
md		Balto		Towson				5511 Septon Ave			
14 FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last									
J. H.		Weber		Cott							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address					
Yes, no or unknown				Wilbur Dumber							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Failure										0	
4124 DUE TO, OR AS A CONSEQUENCE OF (b) F.I.S.C.Y.D										?	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Fractured Hip											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2-13-69		Fx Hip Repair									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c LOCATION Street or RFD No City or Town County State							
		we									
22a. I certify that (1) (this hospital) attended the deceased from 4-25, 1967, to 5-18, 1969, that (1) (we) last saw the deceased alive on 5-16, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED					
Richard Maffezzoli						5/19/69					
22d PHYSICIAN'S NAME (Type)		22e ADDRESS									
Richard MAFFEZZOLI		7501 York Rd. - Towson, Md.									
23a BURIAL, CREMATION		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		5/21/69		Immanuel		Balto					
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Paul Heemann		6067 Hay Rd		MAY 22 1969		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

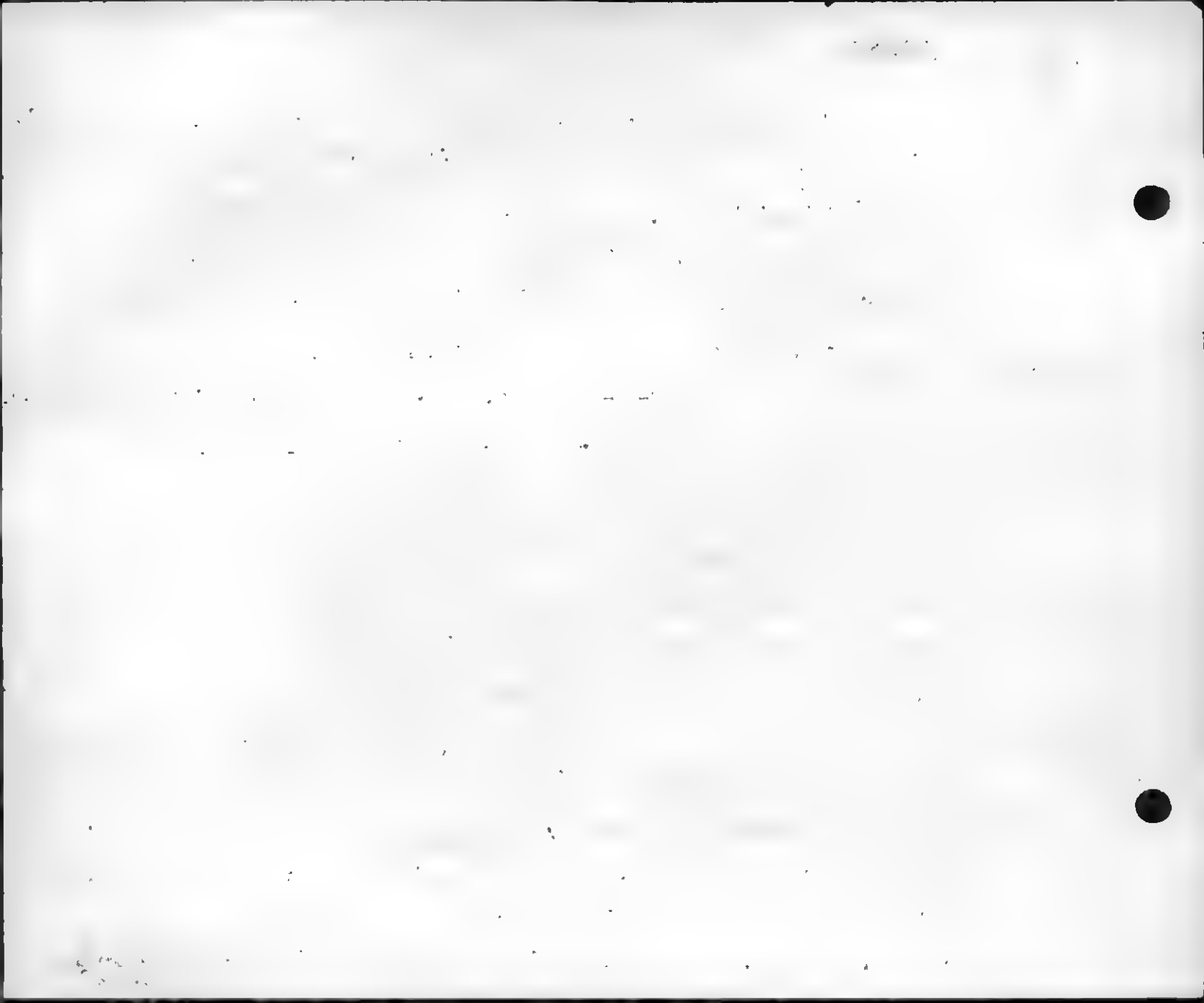
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

VR A15 (4)
30M REV 1/68

<div style="display: flex; justify-content: space-between;"> 06484 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06482 </div>													
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR	
JULIA D. DUNN								MAY 21, 1969				12:15 PM	
3 SEX		4. RACE		5. DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		JANUARY 6, 1900				69 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
AT TOWN, MD.		U.S.A.						BALTIMORE 21204				Md.	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
TOWSON				ST. JOSEPH HOSPITAL				Telephone Company				Retired	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
BALTIMORE				BALTIMORE		DISTRICT				606 CHARLEY MANOR RD.			
14. FATHER'S NAME				15 MOTHER'S MAIDEN NAME									
First Middle Last				First Middle Last									
Peter F. Lanahan				Katherine Pohlmann									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b SOCIAL SECURITY NO.				17 INFORMANT				Address	
				212-32-0319				Mrs. Betty Ann Stewart				1427 North Ivanhoe ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1. Intracerebral hemorrhage, left cerebral hemisphere</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>phere</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>lost.</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 21, 1969, to May 31, 1969, that (I) (we) last saw the deceased alive on May 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (do not) view the body after death.													
22b. SIGNATURE				22c. DATE SIGNED									
[Signature]				May 21, 1969									
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS									
Samuel J. H. Lee, MD.				7620 York Road, Baltimore, Md.									
23a. BURIAL, CREMATION, REINTERMENT (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
BURIAL				6/4/69		Arlington National				Arlington Virginia			
24. FUNERAL DIRECTOR								ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck Inc.								5305 Harford Road 21214		JUN 2 1969		[Signature]	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06485

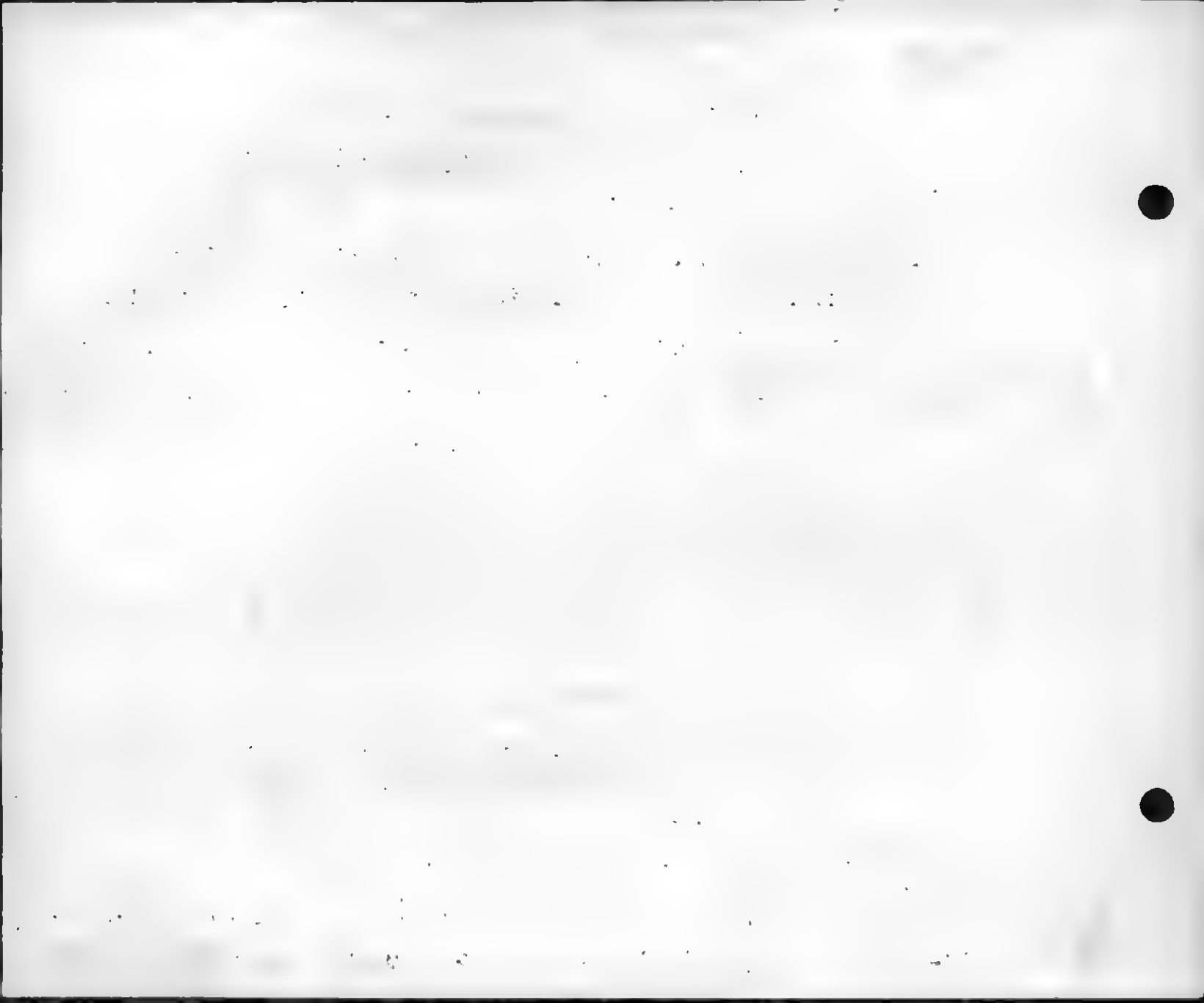
Viola

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06483

1. DECEASED-NAME (Type or print) First Middle Last Viola (Valeria) Dylewski (Iner)			2a. DATE OF DEATH Month Day Year May 27 1969		2b. HOUR P 9:40
3 SEX Female	4 RACE W	5. DATE OF BIRTH May 18, 1888		6. AGE (In years last birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) Russia Poland		7b. CITIZEN OF WHAT COUNTRY? Russia Poland		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) St. Joseph's Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even retired) Picker & Packer	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. STREET AND NUMBER 1103 Haubert St.	
14 FATHER'S NAME First Middle Last Michael Burdinski			15 MOTHER'S MAIDEN NAME First Middle Last Maryanna Rusakowski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 219-28-1042		17 INFORMANT Address Mrs. Sophie Potler 1103 Haubert St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4104 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1 Jan, 1968, to 27 May, 1969, that (I) (we) last saw the deceased alive on 26 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William Goodman MD				22c. DATE SIGNED 27 May 69.	
22d. PHYSICIAN'S NAME (Type) WILLIAM GOODMAN, MD				22e. ADDRESS 1334 SULPAUR SPRING ROAD - 21227	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/31/69		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	
23d. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.		23e. LOCATION (City or Town) (County) (State) Baltimore, Maryland		23f. REC'D BY REGISTRAR DATE MAY 29 1969	
23g. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

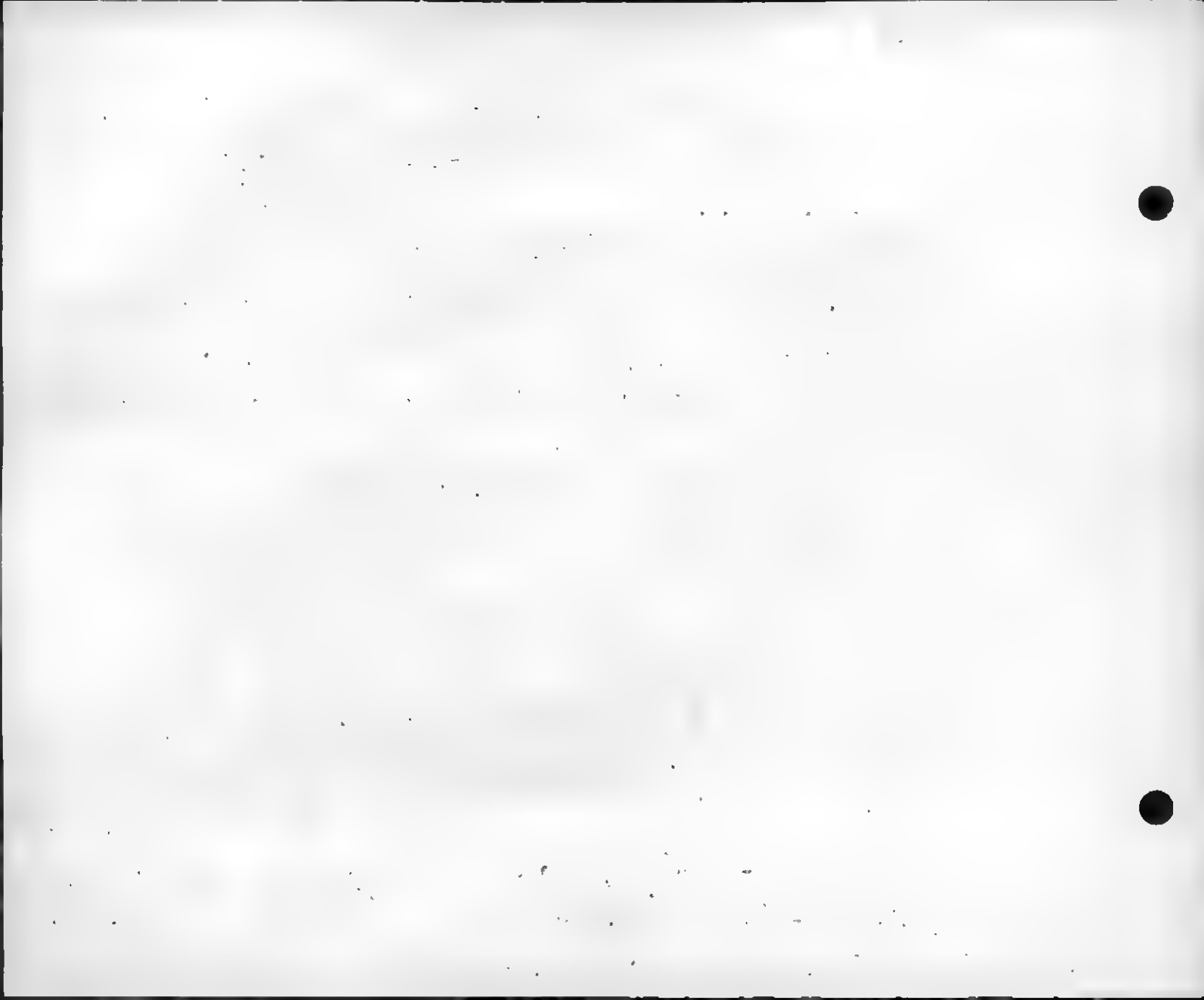
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06486

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06484

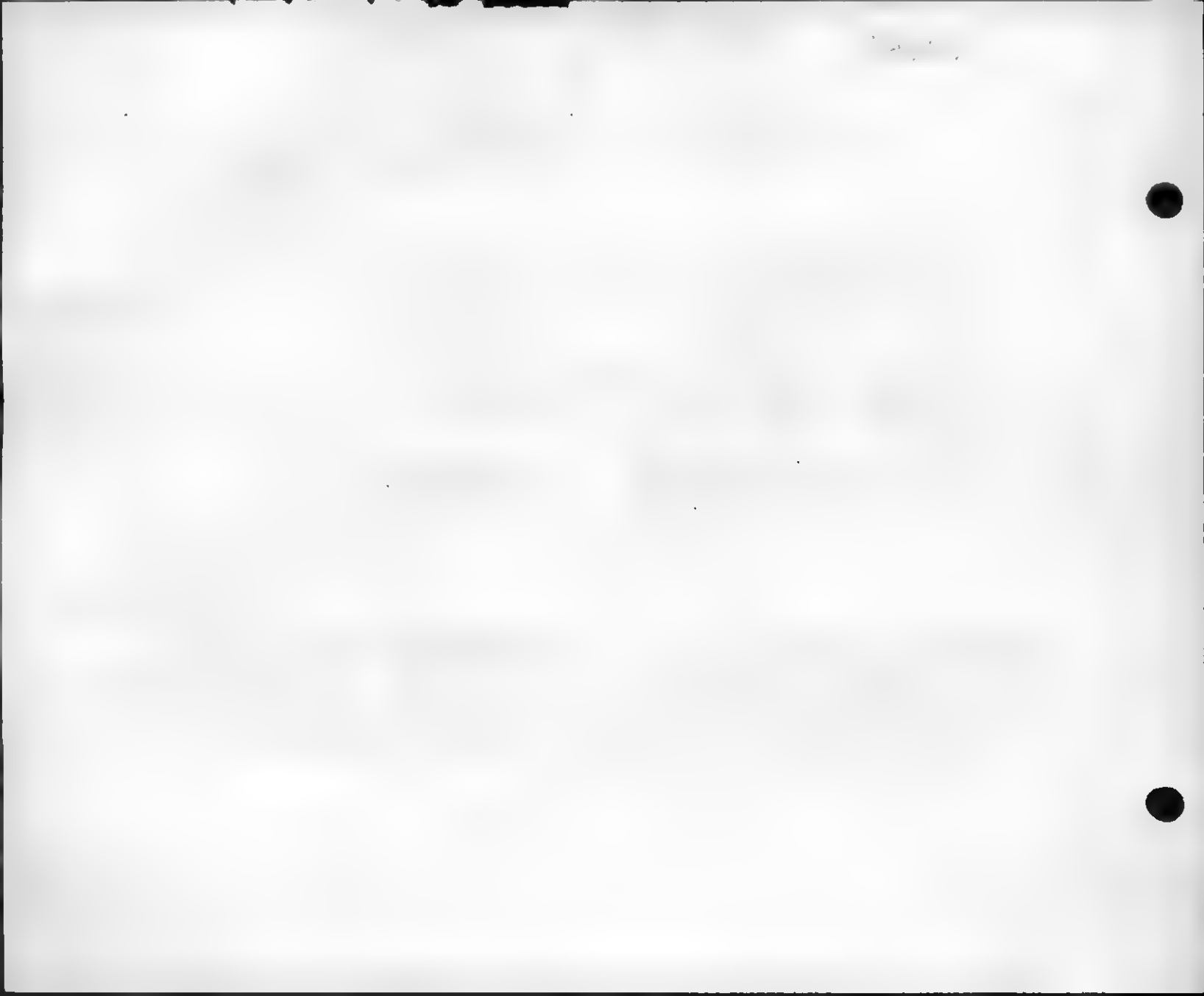
1 DECEASED NAME (Type or print) Amelie Carolyn Elgin			2a. DATE OF DEATH May 12 1969		2b. HOUR 6 PM
3 SEX F	4 RACE W	5 DATE OF BIRTH 4-13-1895		6 AGE (In years last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Balto. Co.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore		Md.
10 CITY OR TOWN OF DEATH Kingsville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sheradale Drive	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Heating Contractor	12b. KIND OF BUSINESS OR INDUSTRY Self empl		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Kingsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rtl Box2 Sheradale Drive	
14 FATHER'S NAME First Anton Middle Lipp Last Schell		15 MOTHER'S MAIDEN NAME First Christina R. Middle Schell Last 21224			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 216-28-6716A		17 INFORMANT Gilbert H. Elgin Address 306 S. Highland Avenue	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4:10 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 9 1969 to May 12 1969 , that (I) (we) last saw the deceased alive on May 9 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William A. Tyson DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 5-12-69	
22d. PHYSICIAN'S NAME (Type) William A. Tyson				22e. ADDRESS Kingsville Md.	
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 5-16-1969	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) Parkville (County) Balto. (State) Md.		
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236			25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
IDA		ELLIOTT						Month 5 Day 13 Year 69		5:30 AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years - last birthday)		IF UNDER YEAR		IF UNDER 24 HRS	
FEMALE		CAUCASIAN		3-20-1880		69 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
MD.		USA				BALTIMORE					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
TOWSON		CHESAPEAKE MANOR		Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
MD.		Baltimore		Baltimore				806 W 33 St.		21211	
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Cannop		Mary Elizabeth Tracey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
No				213-10-8521		Mrs. Donald Whiting		Albuquerque NM			
18 CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
4127 Coronary Occlusion Sudden											
DUE TO, OR AS A CONSEQUENCE OF (b)											
Coronary Renal Vascular 10+ yrs											
DUE TO, OR AS A CONSEQUENCE OF (c)											
Hypertension											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 4/30, 1969 to 5/13, 1969, that (I) (we) lost saw the deceased alive on 5/12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Charles O'Donnell				CHARLES O'DONNELL		7001 York Rd					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
		5/9-69		St Marys (Wardens)		Baltimore		Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Frank W. Setz		814 W 36 St		MAY 15 1969		J. Charles Judge					

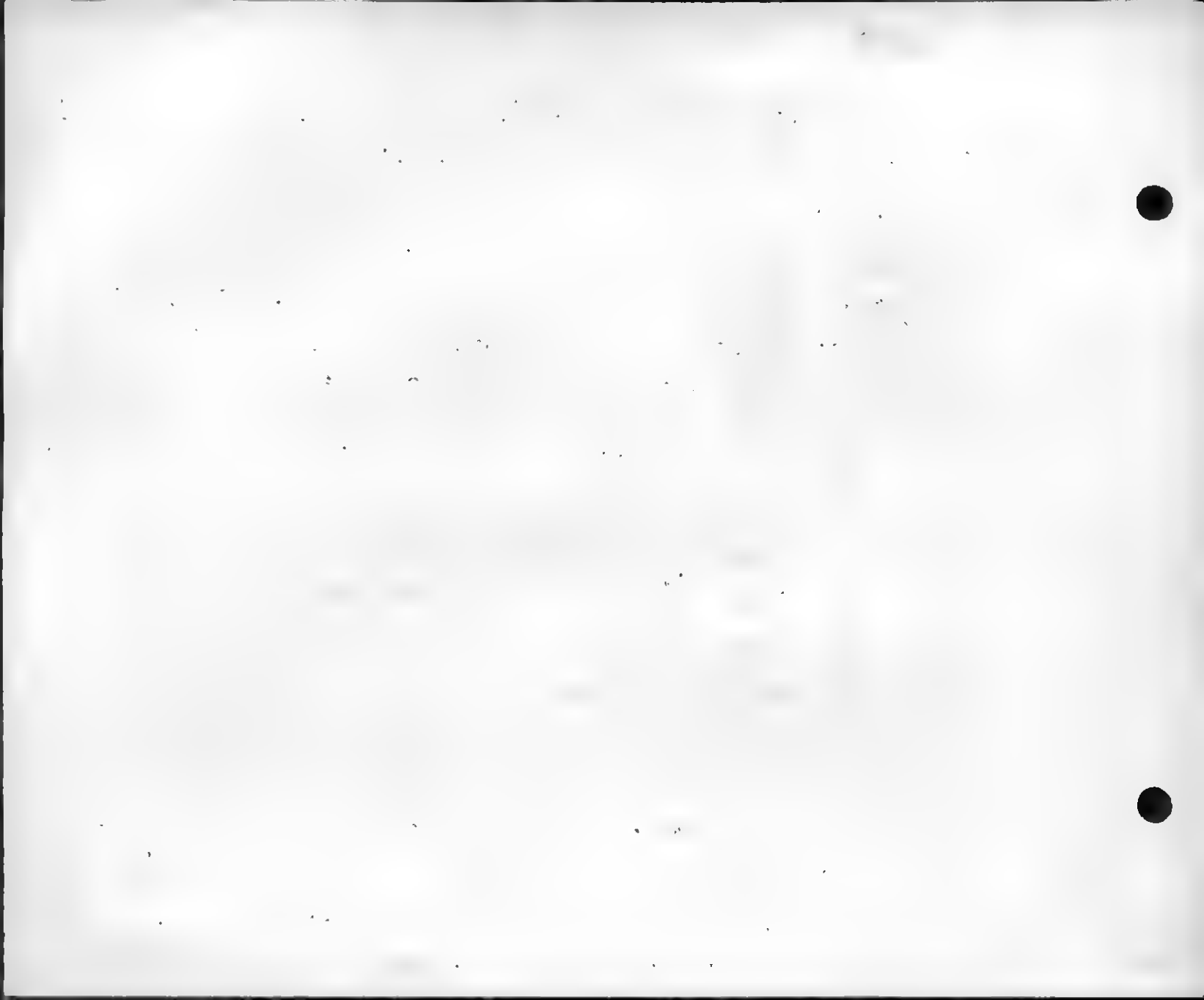


4369

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
EVA MARGARET ELMER						May 22 1967			5 P.M.
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS	
female	Caucasian		Sept. 26. 1893			75 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Brayton, Iowa		USA				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson			Towson Convalescent			Housewife		Teacher	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Baltimore		Baltimore		YES		102 Taplow Rd.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Henry Pearson			Margaret Quinn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
no			579-05-8729 A			John Elmer (Husband) 102 Taplow Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Acute Urinary Tract Infection</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. Kemper Owens</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-22-69	
22d. PHYSICIAN'S NAME (Type) J. KEMPER OWENS M.D.						22e. ADDRESS 6 E. Road St., Balto, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 26. 1969		Druid Ridge Cemetery		Pikesville Md.			
24. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. Baltimore Md.				ADDRESS		25a. REC'D BY REGISTRAR MAY 27 1969		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



3519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

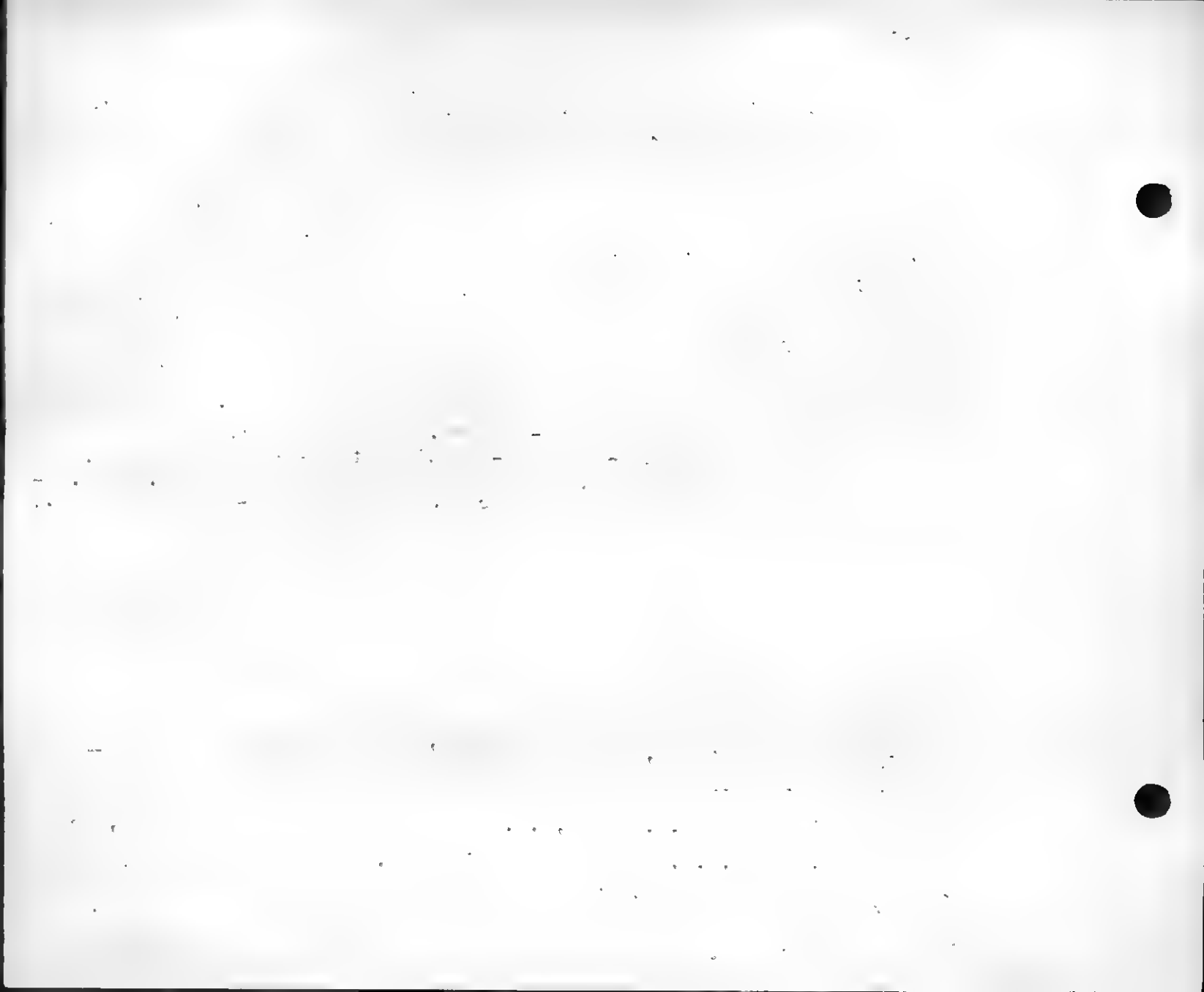
06489

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06487

1 DECEASED-NAME (Type or print) MARGARET Engelbrecht		First Middle Last		2a. DATE OF DEATH Month MAY Day 21 Year 1969			2b HOUR M		
3 SEX F		4 RACE W.		5 DATE OF BIRTH JUNE 7 - 1926			6 AGE (in years last birthday) 42 YRS		
7a BIRTHPLACE (State or foreign country) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md.			
10 CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 2802 King Ridge Rd		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY AT Home		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD		13b COUNTY BALTO		13c CITY OR TOWN Parkville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 2802 King Ridge Rd	
14. FATHER'S NAME First Middle Last James Rupinski		15. MOTHER'S MAIDEN NAME First Middle Last Mary Kwiatkowski							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES, no, or unknown <input type="checkbox"/> NO (If yes, give war or dates of service)		16b SOCIAL SECURITY NO 216-20-7899		17. INFORMANT Benedict Engelbrecht Sr Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest- sudden. Rheumatic heart disease-Class II-III with Starr-Edwards prosthetic valve replacement with some dislodgement-dur.6mons.+/- DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosclerosis and uremia-duration 2 yrs.+ DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 21, 1959 to present , 19 69 , that (I) (we) last saw the deceased alive on May 11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R.V. Rangle, M.D.		22c. DATE SIGNED May 23, 1969		22d. ADDRESS 2938 St. Paul Street (21218)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-24-1969		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD		23d. LOCATION (City or Town) (County) (State) BALTO MD			
24. FUNERAL DIRECTOR CHAS. F. EVANUS		25a. REC'D BY REGISTRAR MAY 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

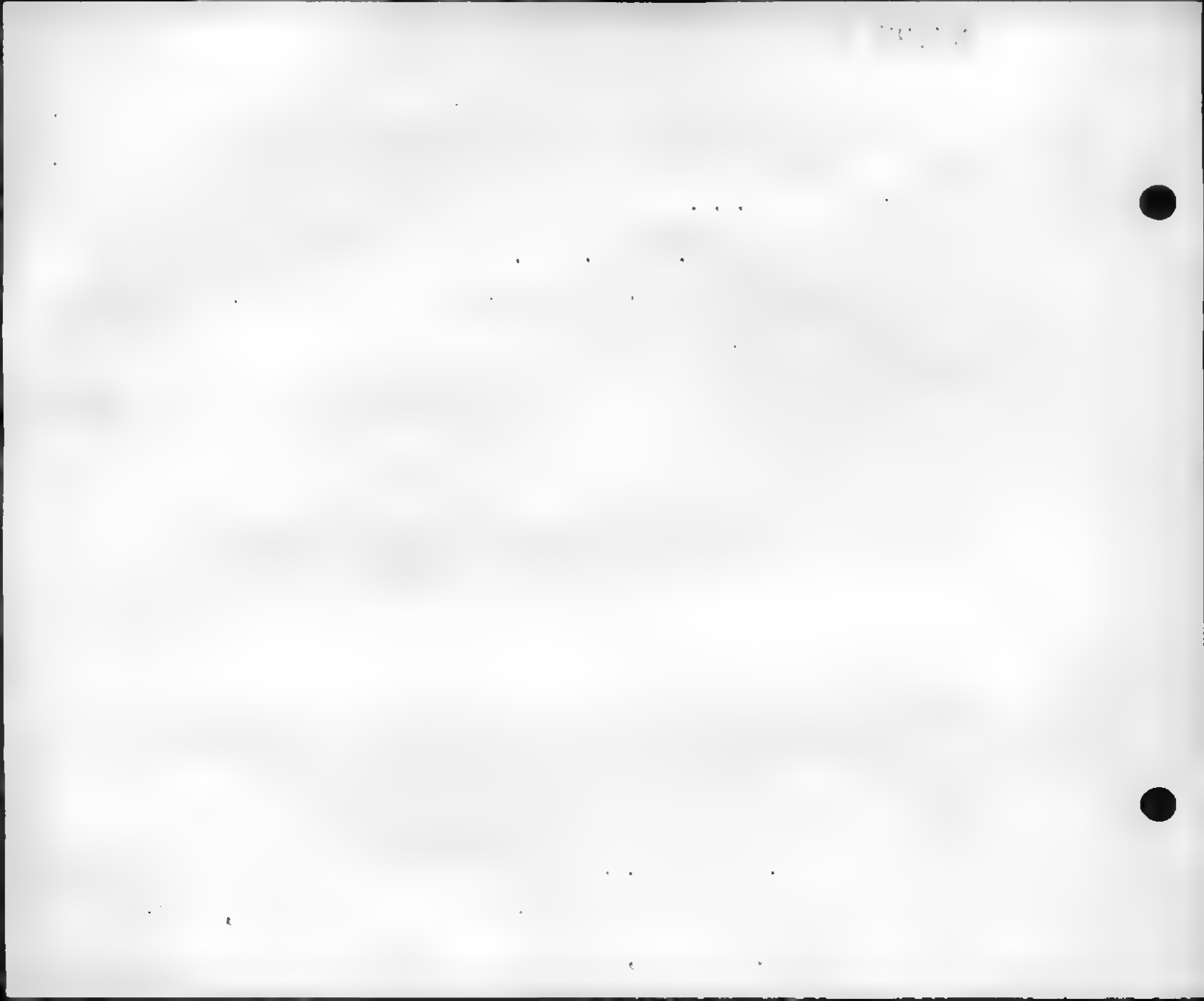


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH Month Day Year		2b. HOJR
CHRISTINE Marie ESPOSITO									May 16, 1969		8:00AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD Month Day Year	
Female	White	March 9, 1969		YRS 2 MONTHS 7 DAYS		HOURS MIN				May 16, 1969 8:00A	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.A.						Baltimore Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Randlestown			Balt. Co Gen. Hosp.			None					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Baltimore			Baltimore			3627 Rockdale Terrace		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Frank J Esposito			Rosemarie Falloni								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			None			Mr Frank J Esposito			Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Death In Infancy</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
2a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			5/16/69		
Ronald N. Kornblum, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			5/19/69		Holy Redeemer			Baltimore, Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J Ruck Inc. Baltimore, Maryland						MAY 20 1969					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06491

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06489

1. DECEASED-NAME (Type or print) First Anna Middle M. Last Estep		2a. DATE OF DEATH 5/16/69 Month Day Year		2b. HOUR 9:15 P M	
3 SEX F	4 RACE White	5 DATE OF BIRTH 8/30/1881		6 AGE (In years last birthday) 81 YRS	7 UNDER 1 YEAR MONTHS DAYS
7b BIRTHPLACE (State or foreign country) Baltimore		7c CIT. ZEP. OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stella Maris Hospice		12a. USUAL OCCUPATION (Kind of work done during life, even if retired) Housewife	
13a USCA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b COUNTY Baltimore	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 2400 Bellona Ave.
14 FATHER'S NAME First Middle Last George Wicklin		15 MOTHER'S MAIDEN NAME First Middle Last Margaret Lorber			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO. 216-56-8657	17 INFORMANT Address Stella Maris Hospice Towson, Md		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4:17 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic brain syndrome</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medico examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/29/68</u> , 19 <u>68</u> , to <u>5/14/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/18/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.					
22b SIGNATURE <u>J. David Nagel</u>				22c DATE SIGNED 5/16/69	
22d. PHYSICIAN'S NAME (Type) J. David Nagel, M.D.				22e ADDRESS 8121 Mockingbird Lane	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5-20-1969		23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d LOCATION (City or Town) Baltimore, Maryland		23e LOCATION (County) (County)		23f LOCATION (State) (State)	
24 FUNERAL DIRECTOR Wm. Cook-B ooks Towson 1050 York Road 21204				25a REC'D BY REGISTRAR DATE MAY 19 1969	
25b REGISTRAR'S SIGNATURE <u>Richard Judge</u>					



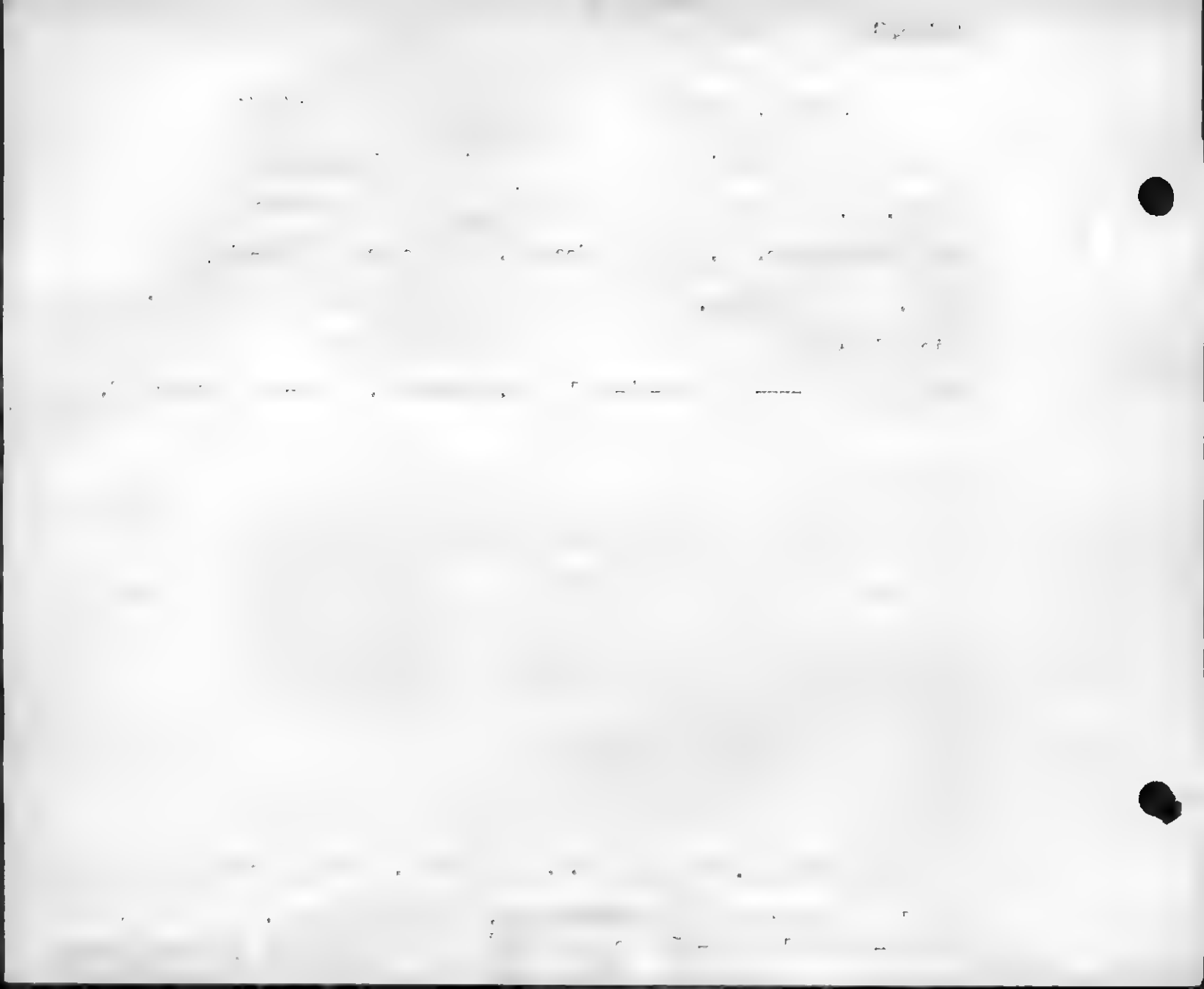
185-
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06492

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06490

1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
JAMES F. FAHEY								5/22/69 Month Day Year		6:30 PM	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7. COUNTY OF DEATH		8. IF UNDER 1 YEAR		9. IF UNDER 24 HRS
Male	White		April 3rd, 1908		61		Baltimore		MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Balto. Md.	USA				Baltimore		Police Officer-City				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
Rogers Forge, Balto. Co.		622 Murdock Rd.									
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. NO. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
Md.		Balto.						622 Murdock Rd.			
4 FATHER'S NAME		First		Middle		Last		15 MOTHER'S M.A.D.E.N. NAME		First Middle Last	
Michael Fahey								Annie Kavney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
no				215-34-0771		Mrs. Frances E. Fahey-622 Murdock Rd.					
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate</u>										2 YEARS	
185x DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)		21f LOCAT. ON Street or R.F.D. No.		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from <u>11-2</u> , 19 <u>68</u> , to <u>5-22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-24-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED			
Francis X. Carmody		M.D.				3201 N. Charles Street					
22d PHYSICIAN'S NAME (Type)						22e ADDRESS					
23a BURIAL-CREMA-TION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		5/26/69		Holy Redeemer		Balto.		Balto.		Md	
24 FUNERAL DIRECTOR		ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Mitchell-Wiedefeld Home-6500 York Rd. 21212						MAY 28 1969		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06493

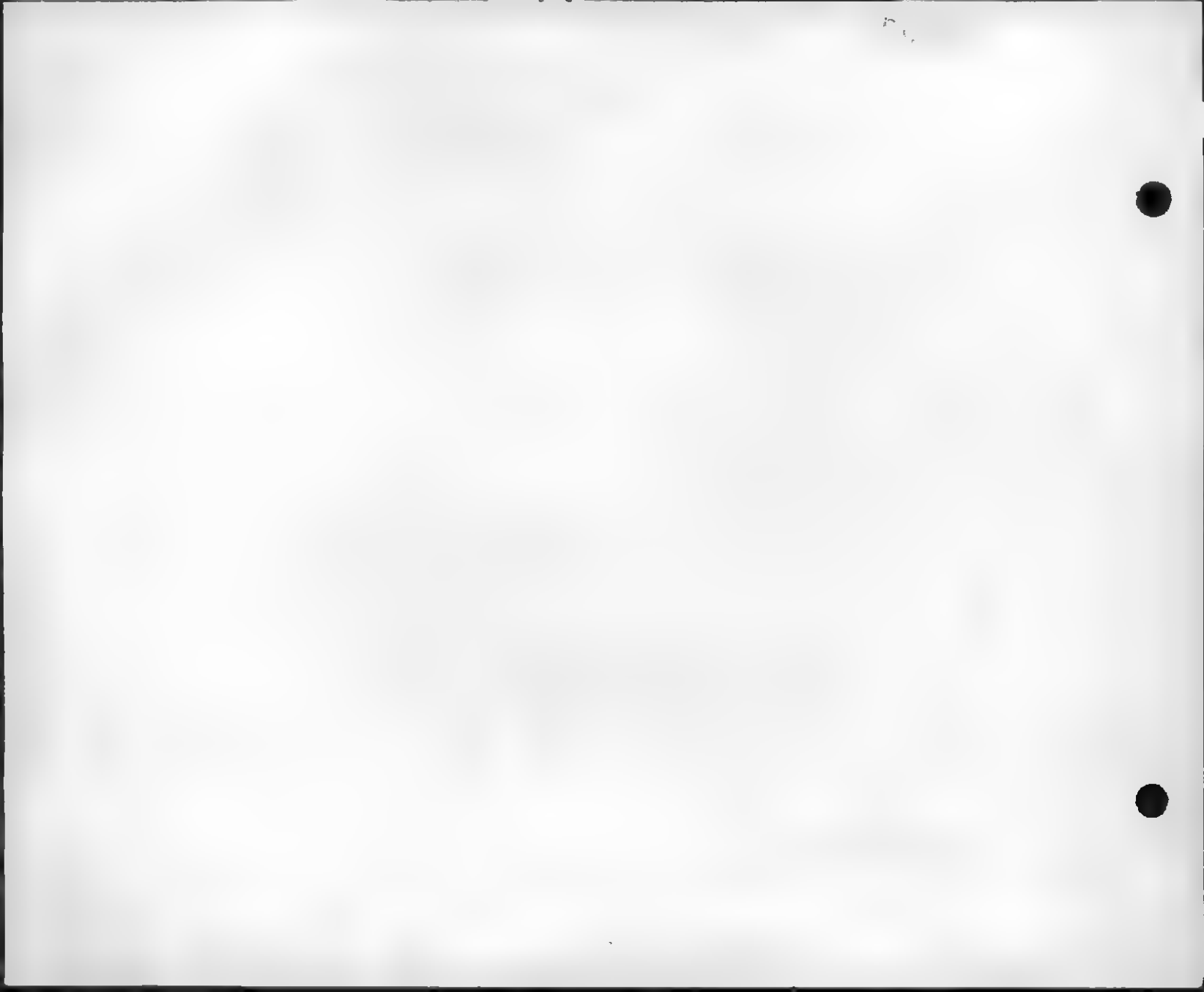
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06491

1 DECEASED NAME (Type or print) Thomas M Fidler			2a DATE OF DEATH 5 Month 6 Day 1969		2b HOUR 12:15 PM
3 SEX male	4 RACE white	5. DATE OF BIRTH Jan 6 1895		6 AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Va.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Catonsville MD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Insurance Salesman	12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md		13b CITY OR TOWN Linthicum	13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 19 Mansion Road	
14 FATHER'S NAME First Middle Last William Fidler		15 MOTHER'S MAIDEN NAME First Middle Last Alice Davis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b SOCIAL SECURITY NO 217-05-1893A		17 INFORMANT Mrs. Fidler Address 19 Mansion Rd. N. Linthicum	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Lt. hemiplegia due to CVA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) diabetes mellitus - renal insufficiency					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING (If either, notify medical examiner) <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from August, 1967, to August, 1969, that (I) (we) last saw the deceased alive on May 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE E.H. Weiss		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 5-6-69	
22d PHYSICIAN'S NAME (Type) E.H. Weiss		22e ADDRESS 615 HAMMILLAS LANE - BALTIMORE - MD			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 5-10-69		23c NAME OF CEMETERY OR CREMATORY LONDON PARK BALTIMORE MD	
23d LOCATION (City or Town) (County) (State) BALTIMORE MD		24a FUNERAL DIRECTOR Geo L. Schwab Funeral Home		25a REC'D BY REGISTRAR Francis H. Miller 2101 Indwick Cove.	
24b REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 9 1969			

VR A15 45M

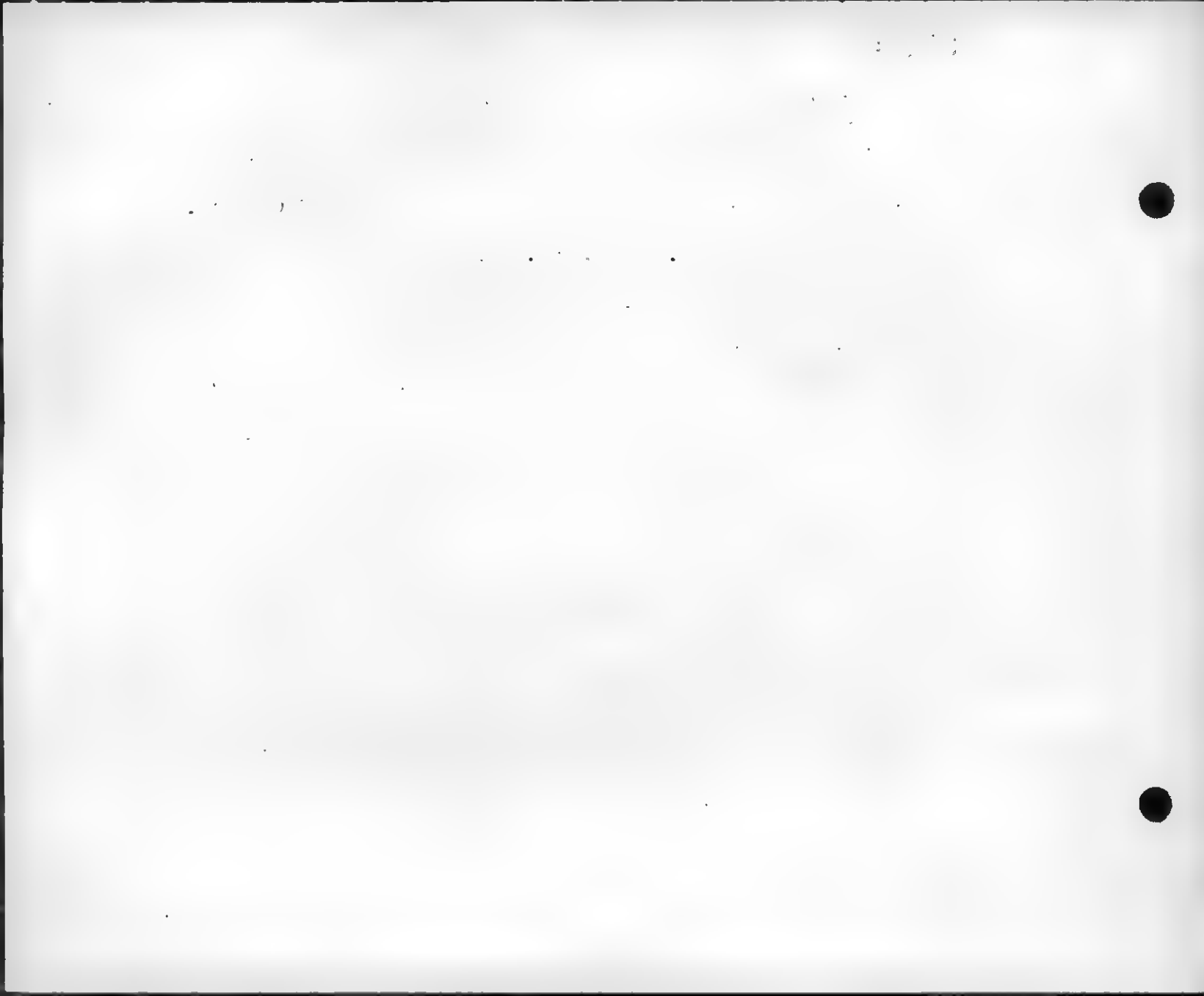


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b. HOUR
CECELIA		KATHERINE		FILLIAUX				05 Month 12 Day 69		1:30 A M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
FEMALE		CAU		1-20-89		80 YRS		MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		U.S.A.				BALTIMORE CO.				
1D CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
TOWSON, MD.		GRTR. BALTO. MED. CENTER								
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d IS DE CITY LIMITS?		13e STREET AND NUMBER		
Maryland		Baltimore		Timonium		YES <input type="checkbox"/> NO <input type="checkbox"/>		43 Gorsuch Road		
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last						
Philip G. Fleischman				Anna				??????????????		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown				16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No				220-44-3042		Mrs. Cecelia Law,		Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE & DIABETES MELLITUS										
23 09 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>5-11-</u> , 19 <u>69</u> , to <u>5-12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-12-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Meshkinpour</i> DEGREE										22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) DR. HOOSHANG MESHKINPOUR										22e. ADDRESS 6701 NORTH CHARLES STREET
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		May 15, 1969		Oak Lawn Cemetery		Baltimore, Maryland				
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Wm. Cook-Brooks Towson,		1050 York Road		MAY 13 1969		<i>John J. Judge</i>				
Towson, Maryland 21204										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06495

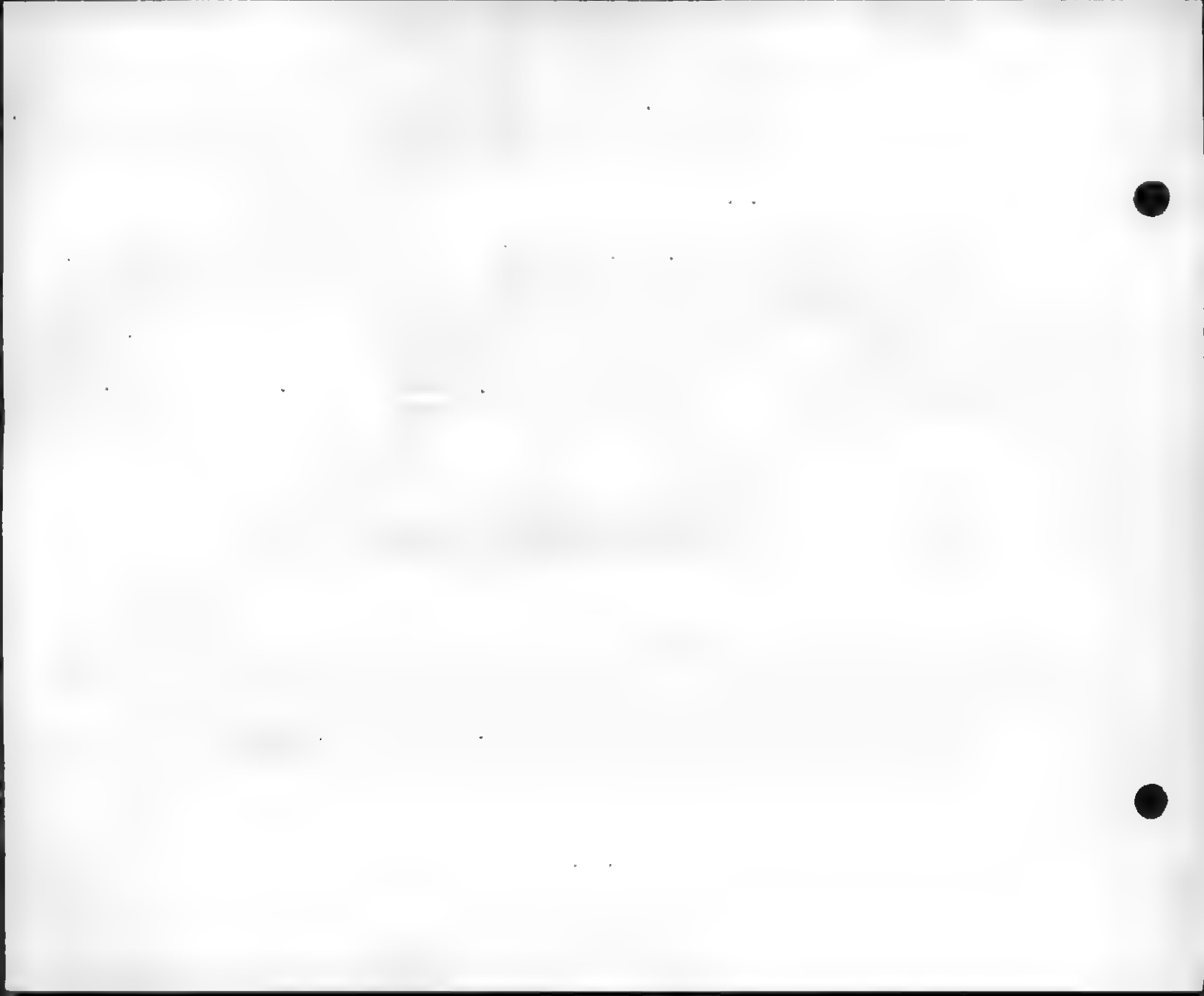
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film G413 5/29/69 kk

CERTIFICATE OF DEATH

06493

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOJR	
FRANK		A.		FISHER	Month 5 Day 14 Year 69		11:20 PM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years or less than day)		IF UNDER YEAR MONTHS DAYS	
MALE	WHITE		7/15/92		74-76 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY	
BALTIMORE, MD.	U.S.A.				BALTIMORE		CONSTRUCTION	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD		VET. ADM. HOSPITAL		PAINTER				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSUR CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND				BALTIMORE				
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		13e STREET AND NUMBER				
First Middle Last		First Middle Last		106 N. Decker Avenue				
JOHN		FISHER		KATE		FINN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
YES		WW I		215 01 12 51		CLIN. RECORDS, VA HOSP. FT HOWARD, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								
PULMONARY EDEMA								
DUE TO, OR AS A CONSEQUENCE OF								
ARTERIOSCLEROTIC HEART DISEASE								
DUE TO, OR AS A CONSEQUENCE OF								
CEREBROVASCULAR INSUFFICIENCY								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		NO AUTOPSY		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that the (this hospital) attended the deceased from 5/6/69, 19, to 5/14/69, 19, that (I) (we) last saw the deceased alive on 5/14/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		22c. DATE SIGNED		
ERHARD J. BUNYOR, M. D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		5/15/69		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
ERHARD J. BUNYOR, M. D.				VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		5/19/69		HOLY REDEEMER		BELAIR RD. BALTIMORE, MD.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REGD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
		MORAN FUNERAL HOME		MAY 19 1969		Charles Judge		
		BALTIMORE & POTOMAC STS		BALTIMORE, MD.				




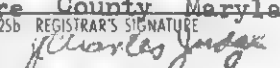
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

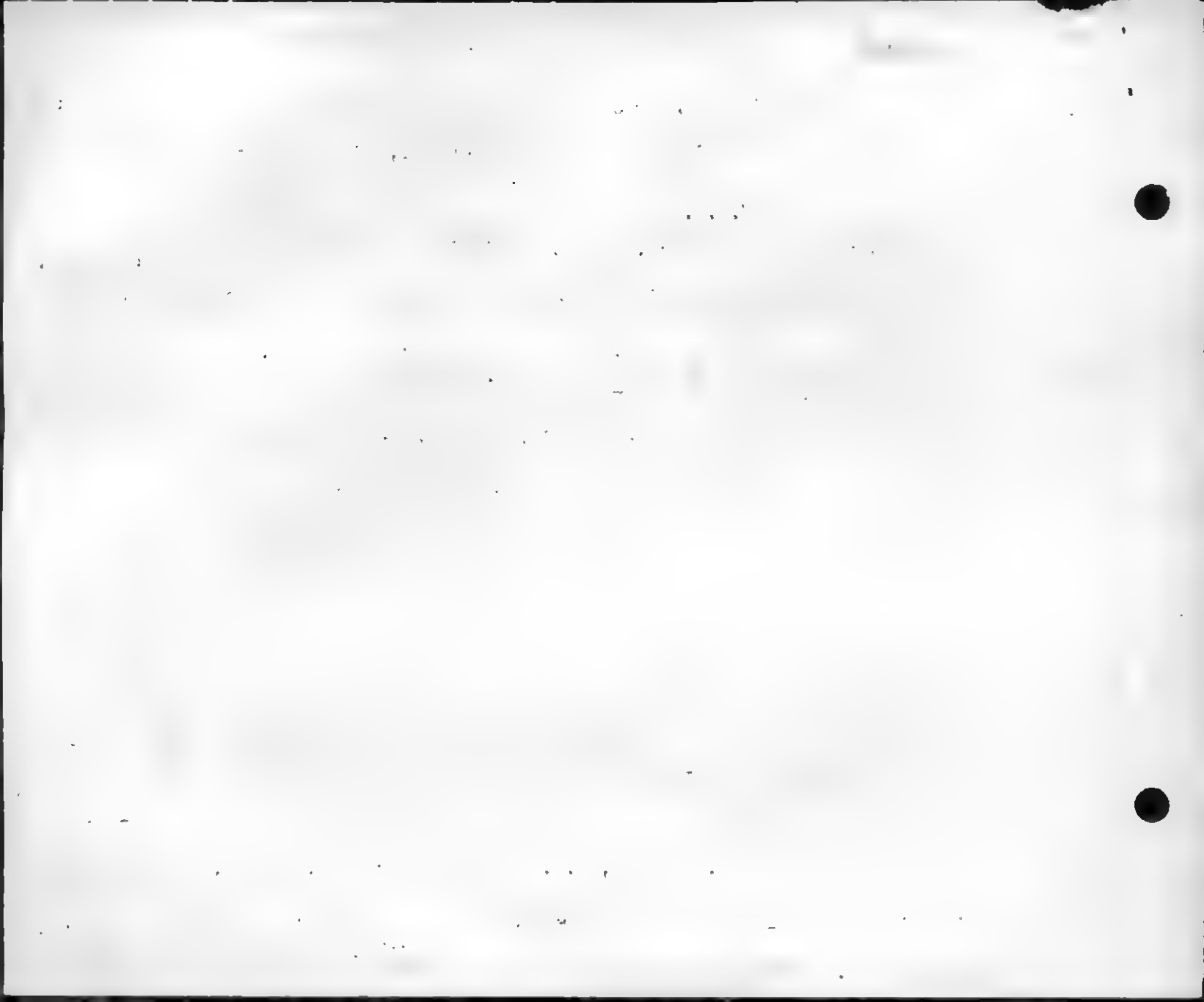
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06496

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06494

1. DECEASED-NAME (Type or print) Robert Pearce Fisher			2a. DATE OF DEATH Month May Day 24 Year 1969			2b. HOUR 8:47 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 1, 1925		6. AGE (In years last birthday) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during last year) Self-employed		12b. KIND OF BUSINESS OR INDUSTRY Road Const.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8331 Edgedale Avenue #21234	
14. FATHER'S NAME First Middle Last Henry Boyd Fisher			15. MOTHER'S MAIDEN NAME First Middle Last Gladys M. Pearce						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16b. SOCIAL SECURITY NO 212-20-5923		17. INFORMANT Wife - Nancy		Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive left intracerebral hemorrhage 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5-24 , 19 69 , to 5-24 , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5-24-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-24-69	
22d. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22e. ADDRESS 7620 York Road, Towson, Maryland 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-27-69		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Baltimore County Maryland			
24. FUNERAL DIRECTOR William E. Johnson				25a. REC'D BY REG STRAR DATE MAY 28 1969		25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

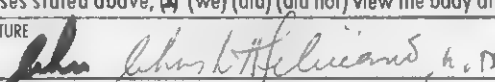

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

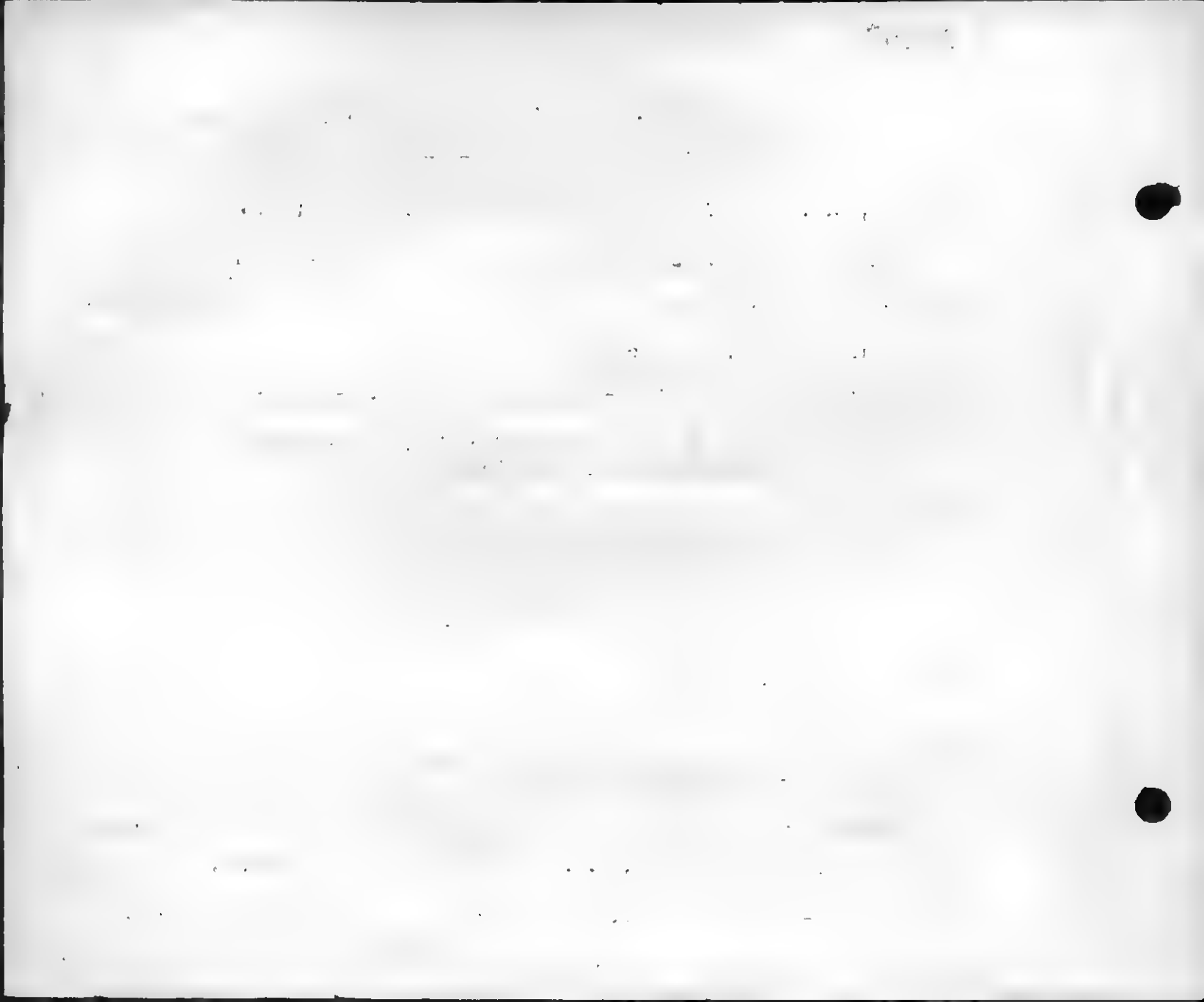
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06497

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06495

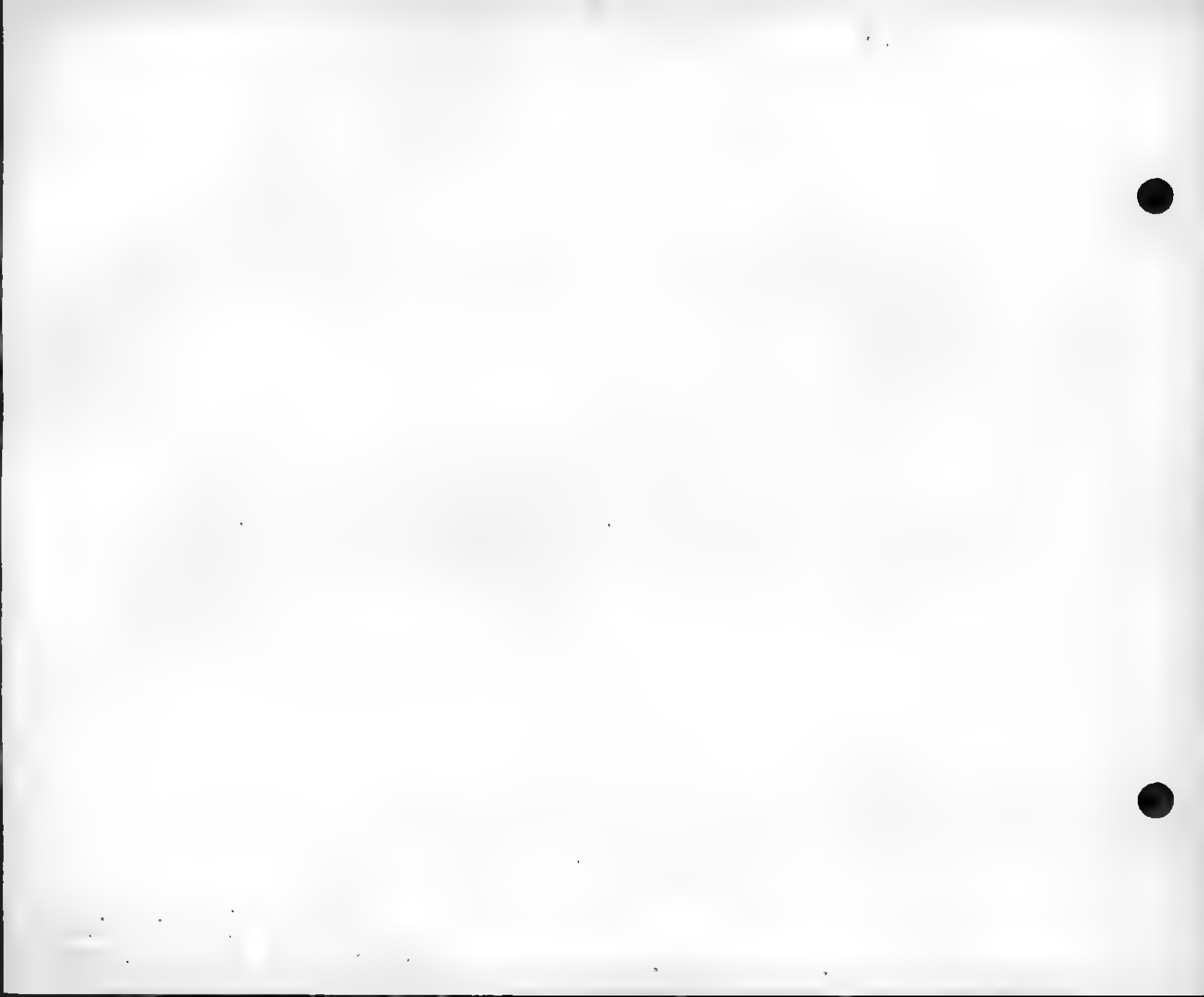
1. DECEASED-NAME (Type or print)		First	Middle	Last	2c. DATE OF DEATH Month Day Year		2b. HOUR A	
MILES		E.		FORD	May 17 1969		12:00	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		3-28-27		42 YRS.		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		
Washington, D.C.		USA				Baltimore Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		St. Joseph's Hospital		Truck Driver				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Baltimore		Baltimore				3406 Woodbine Avenue
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
Miles		E.		Ford	Margaret			Hiener
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes-WW2 Army		212-24-3641		Margaret Celie-3406 Woodbine Avenue #7				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malignant tumor of brain with metastases to								
XXXXXXXXXXXXXXXXX left lung								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from May 11, 1969, to May 17, 1969, that (X) (we) last saw the deceased alive on May 17, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.								
22b. SIGNATURE 					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-17-69	
22d. PHYSICIAN'S NAME (Type) Christine Feliciano, M.D.					22e. ADDRESS 7620 York Road, Towson, Maryland 21204			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5-20-69		Druid Ridge Cemetery		Baltimore, Maryland		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE MAY 20 1969		25b. REGISTRAR'S SIGNATURE 	
Armacost Funeral Chapel-4600 Liberty Hts								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

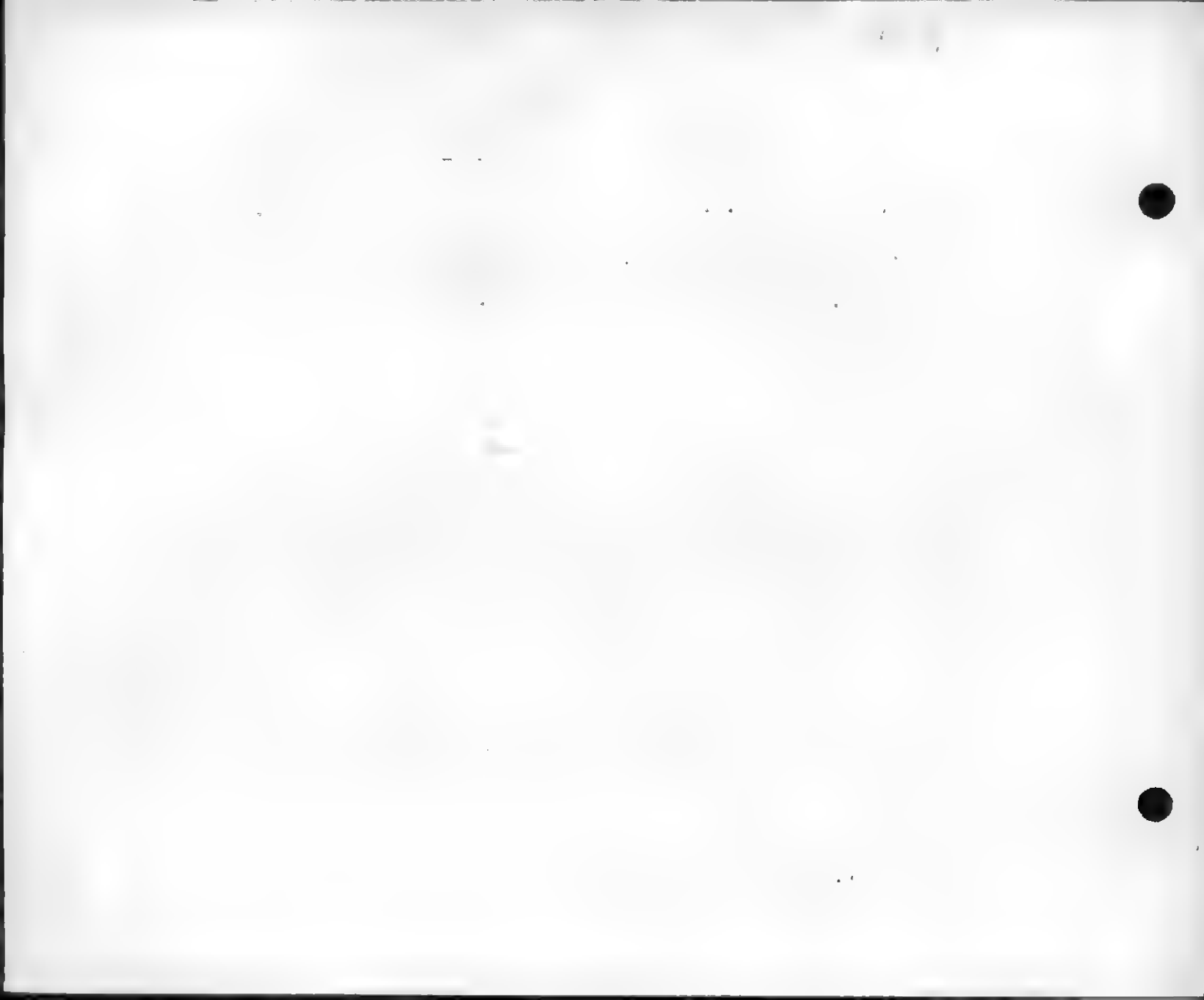
<div> <div>06498</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> </div>																			
1 DECEASED-NAME (Type or print)						First		Middle		Last		2a DATE OF DEATH		2b HOUR					
NORMAN						Devere		FOSLER				Month 5 Day 20 Year 69		9 20 PM					
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)			7 UNDER 1 YEAR			7 UNDER 24 HRS				
M.			W.			4. 6. 03			66 YRS.			MONTHS			DAYS				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH										
BALTIMORE			USA						Baltimore										
0 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY										
BALTIMORE			BCGA			Engineer			B										
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER							
Md.			136			BALTIMORE						702 N. LINWOOD AVE.							
14 FATHER'S NAME			First			Middle			Last			15. MOTHER'S MAIDEN NAME			First				
George						Fosler						Agnes			Kenney				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address										
no						Kenneth Fosler, son,			21214			6611 Fair Oaks							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY.																			
IMMEDIATE CAUSE (a) 1 NARY EDEMA																			
4109 DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																			
(b) ACUTE MI?																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c) ARTERIOSCLEROTIC HEART DISEASE.																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE												22c. DATE SIGNED							
A. Garcia / DR ALLEN												5.20.69							
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS							
BALTIMORE COUNTY GENERAL HOSP																			
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)							
Burial				5/23/69				Rosedale Cemetery				Martinsburg, W. Va.							
24 FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc. 2601 E. Madison St.												DATE MAY 26 1969				Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
Cecelia		M.		Foster		5-2-69			10:10 AM		
3 SEX		4 RACE		5. DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		9-13-1881				87 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED WIDOWED		NEVER MARRIED DIVORCED		9 COUNTY OF DEATH			
Penn.		U.S.						Balto.			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Ralth. - Towson				St. Joseph's							
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.				Balto.		Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		103 Dumbarton Rd. 21212	
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First Middle Last William Geary				First Middle Last Mary Ryan							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service)				16b SOCIAL SECURITY NO		17 INFORMANT Address					
NO				215 22 0600 A		Edna M. Cadigan 103 Dumbarton Rd.					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>											
4125 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>Arteriosclerotic Heart Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-25</u> , 19 <u>69</u> , to <u>5-2-</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-2-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE								DEGREE		22c DATE SIGNED	
Jamie Punzalan										5-2-69	
22d. PHYSICIAN'S NAME (Type)								22e ADDRESS			
Dr. Jamie Punzalan								7620 York Rd. 21201			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		5/5/69		Cathedral Cemetery		Baltimore		Balto.		Md.	
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE			
Mitchell Wiedefeld Home 6500 York Rd.						MAY 6 1969		J. J. J. J.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

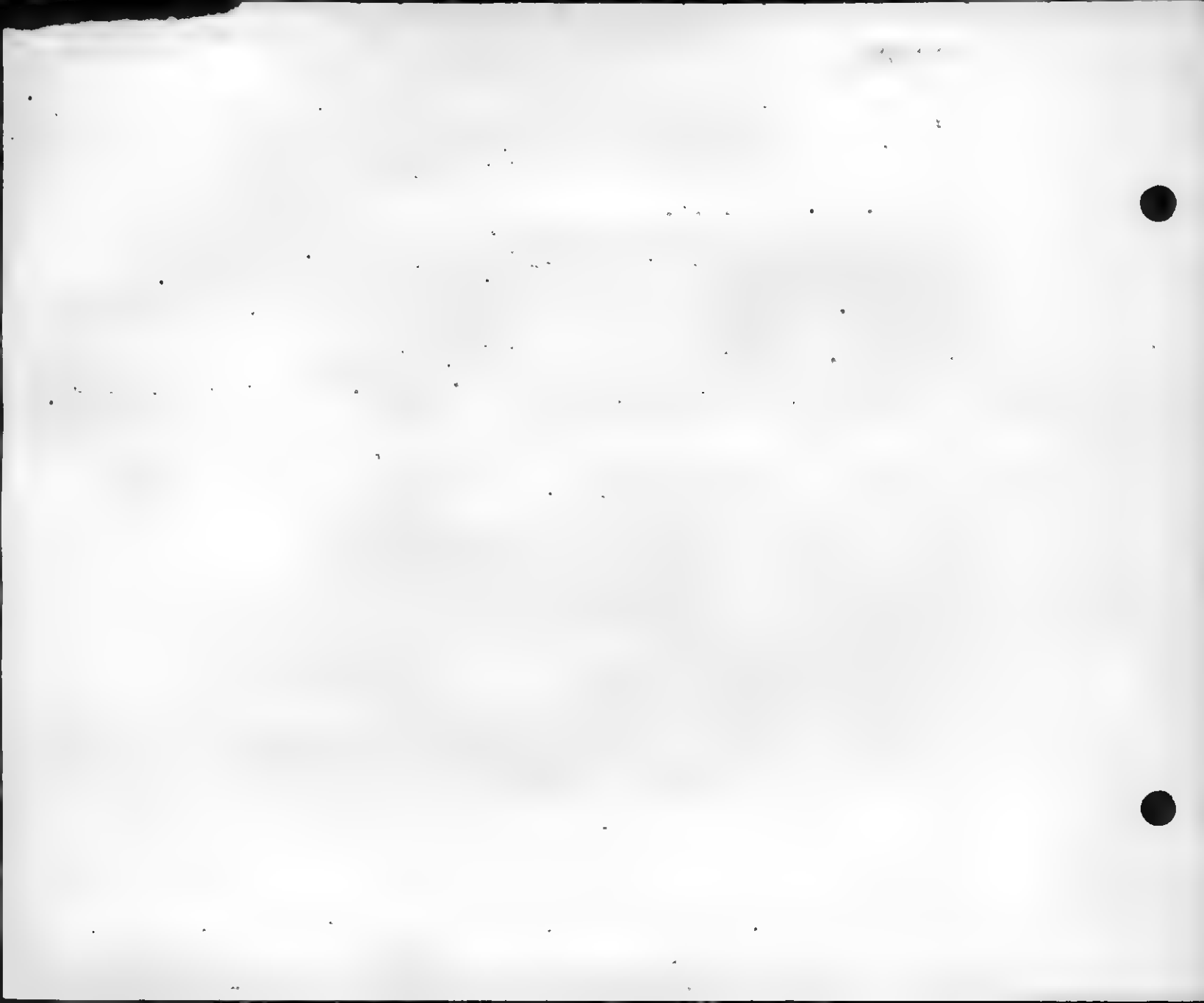
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30M REV. 11-64

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06500

06498

1. DECEASED-NAME (Type or print) Leslie Virginia			First Middle Last Foster			2a. DATE OF DEATH Month Day Year May 3, 1969			2b. HOUR A.M. 8:45		
3. SEX Female			4. RACE White			5. DATE OF BIRTH Jan 29, 1893			6. AGE (In years lost birthday) 76 YRS.		
7a. BIRTHPLACE (State or foreign country) Balto., Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore County, Md.		
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 307 Roanoke Drive			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Victory Liner			12b. KIND OF BUSINESS OR INDUSTRY Candy		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Catonsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 307 Roanoke Drive			14. FATHER'S NAME First Middle Last Charles A. Foster			15. MOTHER'S MAIDEN NAME First Middle Last Anna Lorena Walters			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		
16b. SOCIAL SECURITY NO 213-03-3645A			17. INFORMANT Address Mrs. Ethel L. Dougherty-307 Roanoke Drive			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Longstanding heart failure DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.U. disease - emphysema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 years ?			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State			22a. DATE SIGNED 5/3/69		
22a. I certify that (I) (this hospital) attended the deceased from May 2, 1966 , to May 3, 1969 , that (I) (we) last saw the deceased alive on May 2, 1969 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE D.C. McLaughlin						DEGREE MED. DIRECTOR			22c. DATE SIGNED 5/3/69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE May 6, 1969			23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Sterling Funeral Estate						ADDRESS 736 Edmondson Ave. Catonsville, Md. 21228			25a. REC'D BY REGISTRAR DATE MAY 6 1969		
						25b. REGISTRAR'S SIGNATURE [Signature]					

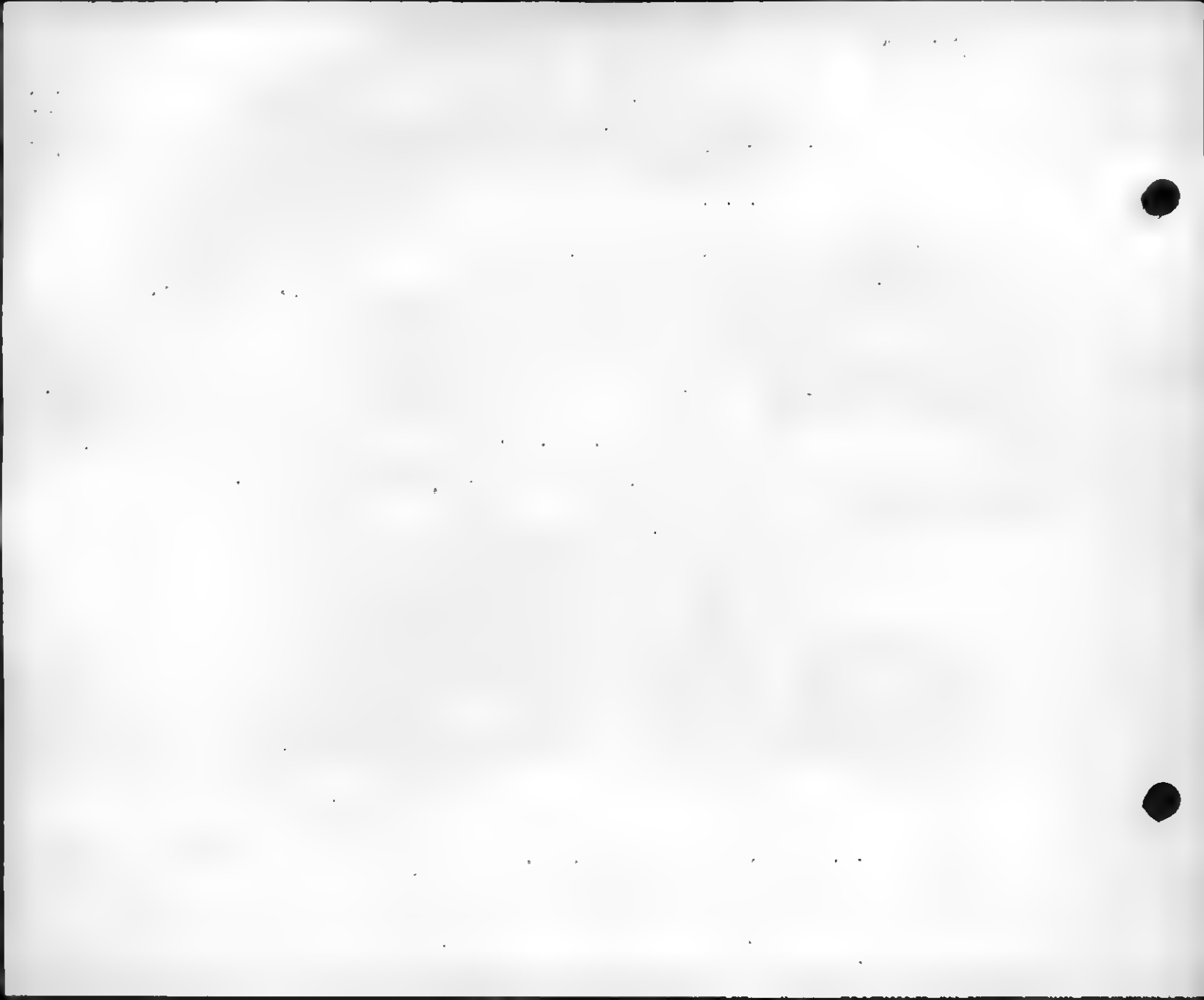


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or Print)		First Patricia		Middle --		Last FOX		2a DATE KNOWN OF EST. <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 1969		2b HOUR 6:05 A.M.	
3. SEX Female		4 RACE White		5 DATE OF BIRTH 4-30-63		6 AGE (in years last birthday) 6 YRS		7 IF UNDER YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		8 IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		2c DATE PRONOUNCED DEAD Month 5 Day 1 Year 1969		2d HOUR 6:05 P.M.	
10 CITY OR TOWN OF DEATH Owings Mills		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) none		12b KIND OF BUSINESS OR INDUSTRY ---					
13a USUAL RESIDENCE (Where deceased lived, if not tuition admission) STATE Maryland		13b COUNTY ---		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1115 Durst St.,			
14. FATHER'S NAME First Tony		Middle ---		Last van Dannaker		15. MOTHER'S MAIDEN NAME First Patricia		Middle --		Last Meyers	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO (If yes give year or dates of service) -----		17 INFORMANT ADDRESS 21117 Rosewood State Hospital, Owings Mills, Md.							
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Grand Mal Seizures, Psychomotor Retardation since birth DUE TO, OR AS A CONSEQUENCE OF (c) Microcephalus Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none											
19a DATE OF OPERATION none		19b CONDITION FOR WHICH OPERATION WAS PERFORMED? none						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) none							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) none		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		D.D. Caples, Reisterstown, Md.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b DATE SIGNED 5/1/69 Baltimore	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE May 6/69		23c NAME OF CEMETERY OR CREMATORY B. Ford Med. School		23d LOCATION (City or Town) Baltimore, Md.		(County)		(State)	
24 FUNERAL DIRECTOR J. J. P. Funeral Home, Baltimore		ADDRESS		25a RECEIVED BY REGISTRAR DATE MAY 9 1969		25b REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15
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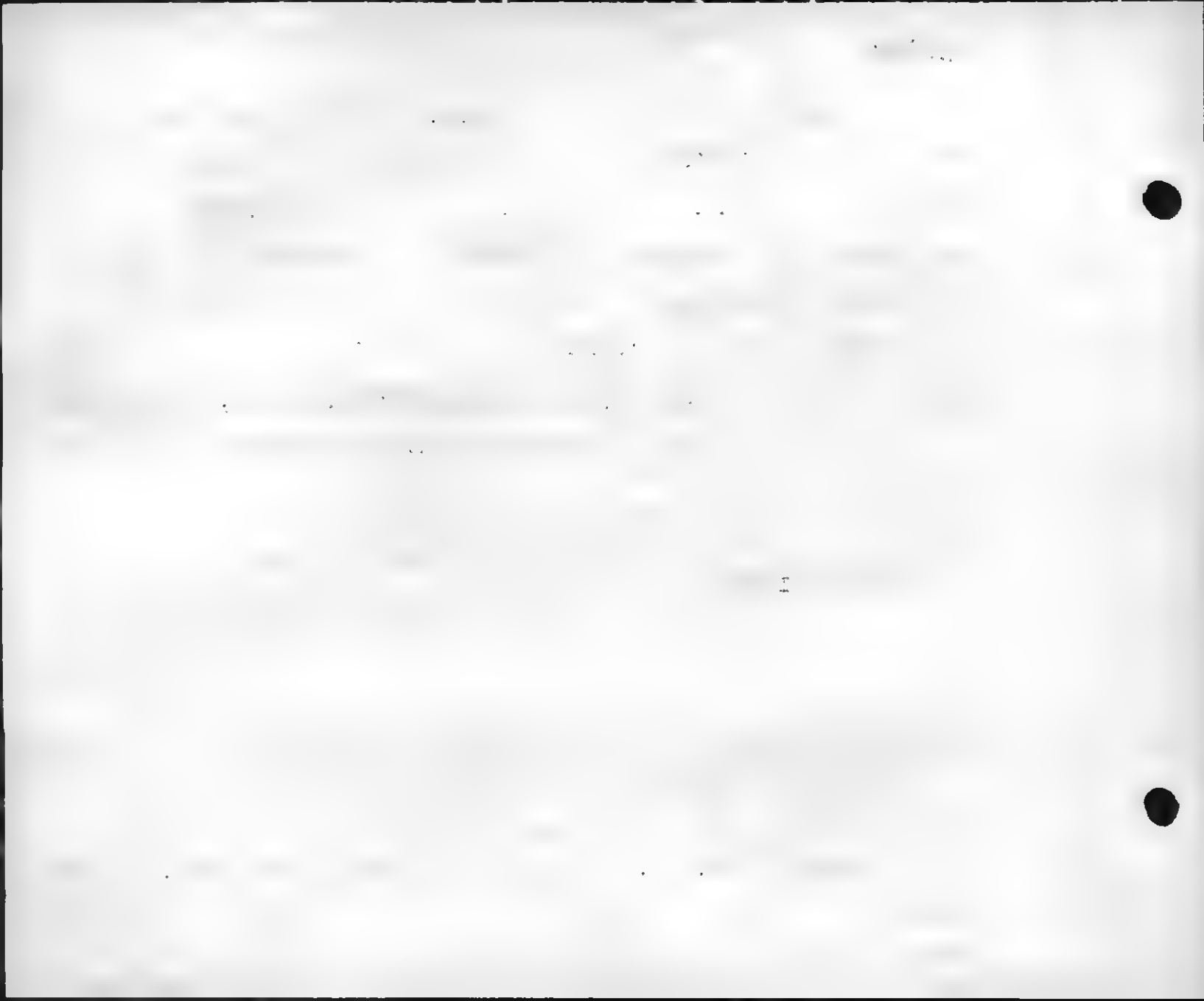
06502

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06500

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR	
THOMAS				FRAZIER	Month MAY, Day 11, Year 1969		10:30 AM	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE	CAUCASIAN		JUNE 29, 1894		74 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND	U.S.A.				BALTIMORE			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD		VETERANS ADMINISTRATION HOSPITAL		CARPENTER		CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b. CITY		13c CITY OR TOWN		13d INS DE CITY L.M.S?		13e STREET AND NUMBER
STATE MARYLAND		BALTIMORE		ESSEX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		144 POPIAR ROAD
14. FATHER'S NAME		15 MOTHER'S MA DEN NAME						
First Middle Last		First Middle Last						
GEORGE A FRAZIER		MARY HOLTON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT				
YES		WW I		Address				
		213 09 9245		CLINICAL RECORDS, VA HOSP, FT HOWARD, MD				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC PULMONARY EMPHYSEMA AND BRONCHITIS								years
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
DIABETES MELLITUS								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from 5-10-69, 19__, to 5-11-69, 19__, that (X) (we) last saw the deceased alive on 5-11-69, 19__, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (not) view the body after death.								
22b SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED		
						5-11-69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
PETER V JUVAN, M.D.		VA HOSPITAL, FORT HOWARD, MARYLAND						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		5/14/69		LONDON PARK		BALTO. MD		
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
CONNELLEY FUNERAL HOME, 300 MACE AVE, BALTO, MD				DATE MAY 15 1969				

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

06503

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06501

1 DECEASED NAME (Type or Print) CHARLES JOHN FRIEDEL			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5-1-1969			2b HOUR 6:45 P.M.		
3 SEX Male	4 RACE Cau	5 DATE OF BIRTH Jan. 31, 1900	6 AGE (In years last birthday) 69 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS		IF UNDER 24 HRS. HOURS		2c DATE PRONOUNCED DEAD May 1, 1969		2d HOUR 6:45 P.M.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CIT ZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md					
10 CITY OR TOWN OF DEATH Essex 21221			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 701 Norris Lane			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tool and Die Maker			12b KIND OF BUSINESS OR INDUSTRY Aircraft		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Essex 21221		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 701 Norris Lane		
14 FATHER'S NAME George C. Friedel			First Middle Last			15 MOTHER'S MAIDEN NAME Magdalene Kraus			First Middle Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO 214 01 3150			17 INFORMANT Charles C. Friedel 703 Norris Lane Balto 21					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V-Disease 4124 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE M.B. Davis M.D. EXAMINER'S NAME (Type) Melvin B. Davis, M.D. 6800 Mornington Road Dundalk Md. 21222 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b. DATE SIGNED 5/2/69											
23a. BURIAL, CREMATION, or other disposal (Specify) Burial			23b. DATE 5/5/69			23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Brazdzinski Funeral Home 1407 Eastern Ave.						25a. REC'D BY REG STRAR MAY 5 1969			25b. REG STRAR'S SIGNATURE Charles Judge		



1519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																							
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>17 E. Burke Avenue</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>17 E. Burke Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>Sara Pennington Gambrill</u>			4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1969</u>			5. SEX <u>female</u>			6. COLOR OR RACE <u>white</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH <u>June 14 1897</u>			9. AGE (in years last birthday) <u>71</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>			IF UNDER 1 YEAR	Months	Days				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
IF UNDER 1 YEAR	Months	Days																					
13. FATHER'S NAME <u>Pennington</u>						14. MOTHER'S MAIDEN NAME <u>Family records</u>																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>Family records</u>			Address														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach & metastases</u> 1519 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>6-12 mps.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 29</u>, 19<u>67</u> to <u>May 2</u>, 19<u>69</u>, that (I) (we) last saw the deceased alive on <u>April 30</u>, 19<u>69</u>, and that death occurred at <u>3:35</u> P.M. from the causes and on the date stated above.																							
22a. SIGNATURE <u>F.M. DUGAN</u>												22b. DATE SIGNED <u>5/5/69</u>											
22c. PHYSICIAN'S NAME (Type) <u>F.M. DUGAN, M.D.</u>												22d. ADDRESS <u>15 E. Biddle St.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/5/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Towson Md.</u>													
24. FUNERAL DIRECTOR <u>John Burns Sons</u>				ADDRESS <u>Towson, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 8 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06505

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06503

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month 5 Day 29 Year 69		2b. HOUR 1:15pM	
Jill		Joann		GARBER				
3 SEX Female		4 RACE White		5 DATE OF BIRTH March 8, 1969		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS 2 DAYS 21
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		10 UNDER 24 HRS HOURS MIN
10 CITY OR TOWN OF DEATH Owings Mills		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if ret red) none		12b KIND OF BUSINESS OR INDUSTRY		MD
13a USUAL RESIDENCE (Where deceased lived, if inst tut on. Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 12905 Kilgore Road
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Bruce		Daniel		GARBER	Eleanor		McClements	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) no		16b SOCIAL SECURITY NO. -----		17 INFORMANT Rosewood Records, Owings Mills, Md. 21117				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute passive Congestive Heart Failure Pulmonary</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congenital Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Intellectual. 2nd Multiple Congenital Abnormalities Hydrocephalus</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No.		City or Town County State		
22a I certify that (I) (this hospital) attended the deceased from May 12, 1969, to May 29, 1969, that (I) (we) last saw the deceased alive on May 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <i>Richard A. Jones</i>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d PHYSICIAN'S NAME (Type) Richard A. Jones		22e ADDRESS Rosewood State Hosp., Owings Mills, Md. 21117						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 6/3/69		23c NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d LOCATION (City or Town) Owings Mills, Md.		
24 FUNERAL DIRECTOR T. F. Elyne & Sons		ADDRESS Reisterstown, Md.		25a REC'D BY REGISTRAR JUN 8 1969		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>		

VR A15
45M



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-100. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06506

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06504

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR					
GEORGE			M. GARNER			5			31 19			69 1 P.M.					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR						
Male	Negro	7-27-14	54 YRS	MONTHS DAYS		HOURS MIN		Month Day Year			31 19 69 1 P.M.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH								
Washington D.C.			USA						Balto.			Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Catonsville			213 Apt. B. Melvin Ave.						Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER					
Md.			Balto.			Catonsville			YES <input type="checkbox"/> NO <input type="checkbox"/>			213 Apt. B Melvin Ave.					
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last											
George Garner						Inez Abbott											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO. (If yes, give year of dates of service)						17. INFORMANT					
						576123403						Jean V. Webb 208 S 6th Av, n.y. George H. Garner, Jr. Same as deceased					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>																	
41-4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
												XXXXX NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8)									
				19													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Edward F. Wilson</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED					
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						6/1/69					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						ADDRESS (Street, city, town, or county)											
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				6-5-69				Balto Nat'l Cemetery				Baltimore, Maryland					
24. FUNERAL DIRECTOR								25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Norton & Dyett, P. O. Balto., Md.								JUN 5 1969				Charles Judge					



06507

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

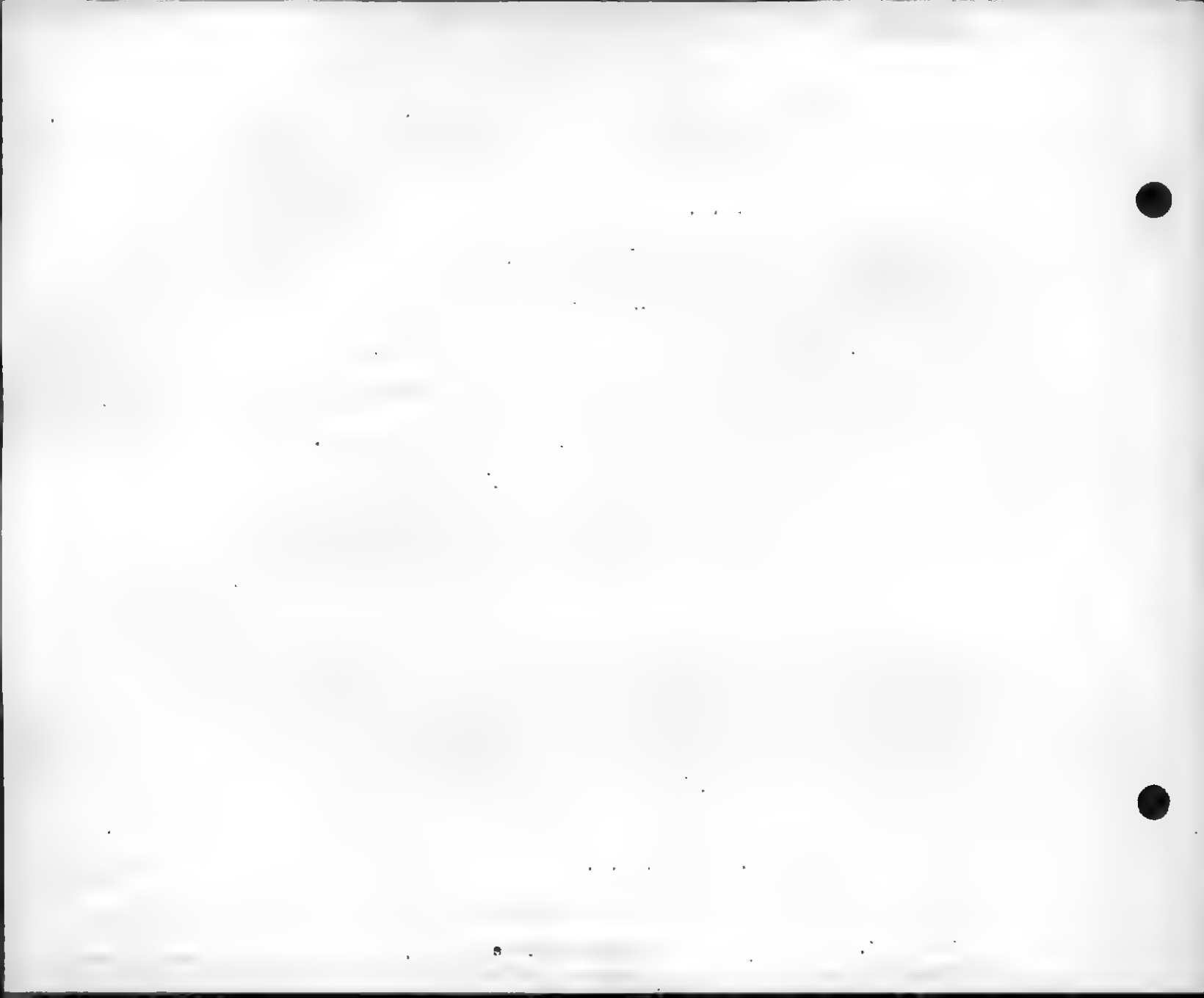
CERTIFICATE OF DEATH

06505

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR P M		
JOHNNIE		H		GAY, JR.	MAY 29, 1969		8:50 P		
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE	CAUCASIAN		1/17/01		68 YRS				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10b KIND OF BUSINESS OR INDUSTRY		
GEORGIA	U.S.A.				BALTIMORE		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		HOSPITAL VETERANS ADMINISTRATION		PLUMBER					
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d NO. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND		ANNE ARUNDEL		MILLERSVILLE				BOX 251	
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last					
Unknown				Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address					
YES WW II		253 14 9281		CLINICAL RECORDS, VA HOSP, FT HOWARD, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cardiac disease</u> (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>(2) Cerebral Vase Accident & Hemiplegia</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that NO (this hospital) attended the deceased from <u>5/20/69</u> , 19 <u>69</u> , to <u>5/29/69</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5/29/69</u> , 19 <u>69</u> , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, NO (we) did not view the body after death									
22b SIGNATURE <u>Phillip M. Ashman</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>						22c DATE SIGNED 5/30/69			
22d PHYSICIAN'S NAME (Type) PHILLIP M. ASHMAN, M.D.				22e ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND					
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		6-4-1969		Glendale National Cemetery		Richmond, Virginia			
24. FUNERAL DIRECTOR NAME (Type) Howard H. Hubbard, 4107 Wilkens Avenue, R.D. JUN 3 1969				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06508

06506

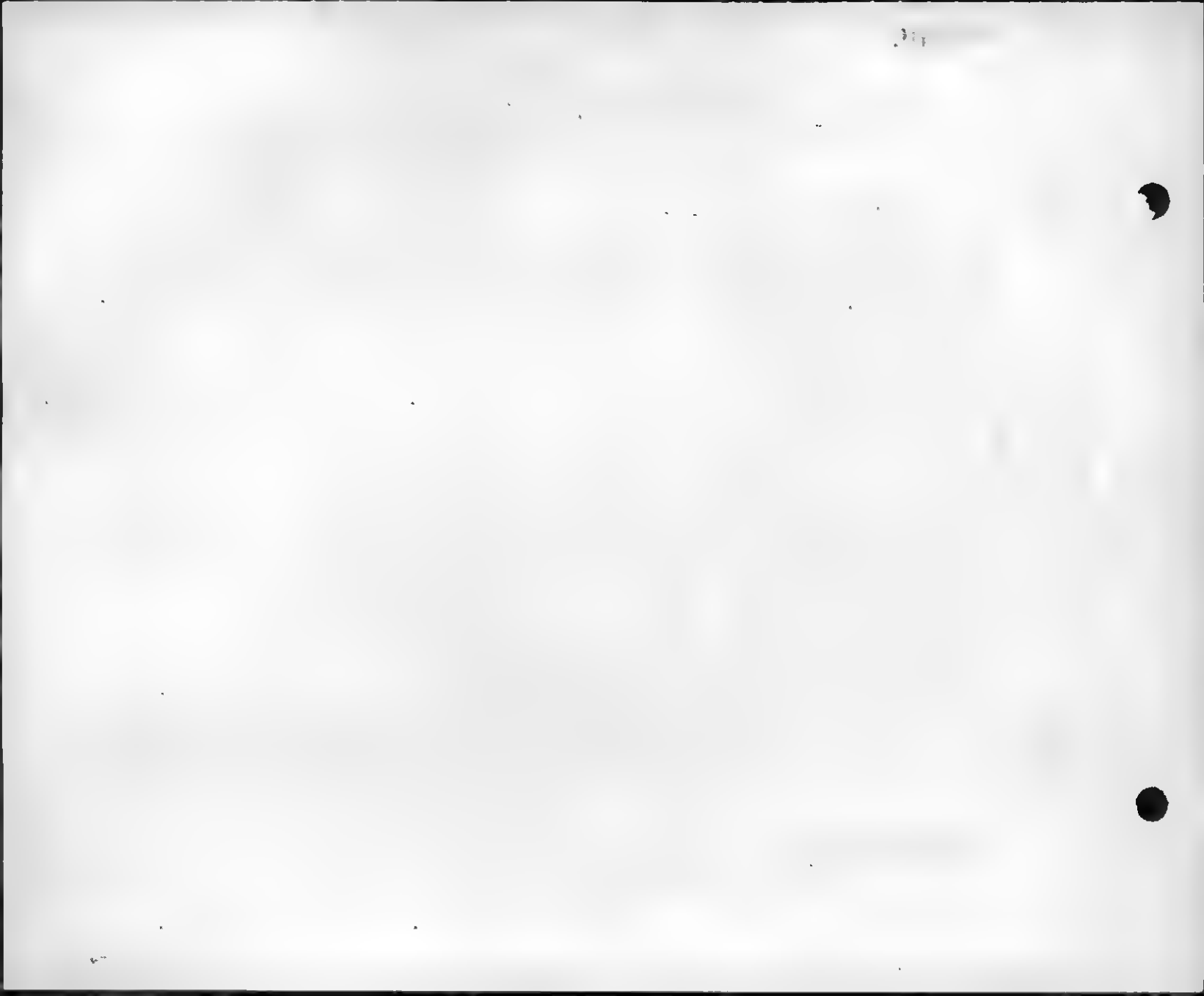
1. DECEASED-NAME (Type or print) <i>George C. Gurst</i>			2a. DATE OF DEATH Month <i>5</i> / Day <i>28</i> / Year <i>69</i>			2b. HOUR M				
3 SEX <i>male</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>11/19/1883</i>		6. AGE (In years lost birthday) <i>85</i> YRS.		7. UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Ind.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.				
10. CITY OR TOWN OF DEATH <i>Perryville Ind.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Newport Lane</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY OWNED <i>business</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Ind.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Perryville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Newport Lane</i>		
14. FATHER'S NAME First Middle Last <i>Peter Gurst</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Butt</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>224-14-800</i>		17. INFORMANT <i>Mary Fitch Newport Lane</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>1109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic coronary disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec</i> , 19 <i>62</i> to <i>May 28</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>May 27</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (die) (did not) view the body after death.										
22b. SIGNATURE <i>Louis Semetoff</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED <i>5/28/69</i>				
22d. PHYSICIAN'S NAME (Type) <i>LOUIS SEMETOFF</i>						22e. ADDRESS <i>2108 Owens Rd Balto Md 21220</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>5/31/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Balto. Ind.</i>				
24. FUNERAL DIRECTOR <i>Assad's Funeral Home Balto. Md.</i>		ADDRESS <i>5401 Belvoir</i>		25a. REC'D BY REGISTRAR <i>JUN 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>				



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) <u>Sebastian GIBILISCO</u>		Last <u>(GIBILISCO)</u>		2a DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>1969</u>			2b HOUR <u>7:45</u> M			
3 SEX <u>male</u>		4 RACE <u>white</u>		5. DATE OF BIRTH <u>5/3/81</u>			6. AGE (in years last birthday) <u>88</u> YRS		7 UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>	
7a BIRTHPLACE (State or foreign country) <u>Italy</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u>			10 UNDER 24 HRS HOURS <u> </u> MIN <u> </u>	
10 CITY OR TOWN OF DEATH <u>Baltimore</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Summit</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>retired</u>			12b KIND OF BUSINESS OR INDUSTRY <u>unknown</u>			
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <u>Md.</u>		13b COUNTY <u>Landsdown</u>		13c CITY OR TOWN <u>Landsdown</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <u>3515 Clover Ave.</u>		
14 FATHER'S NAME First <u> </u> Middle <u> </u> Last <u> </u> <u>unknown</u>				15 MOTHER'S MAIDEN NAME First <u> </u> Middle <u> </u> Last <u> </u> <u>unknown</u>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>no</u>		16b SOCIAL SECURITY NO <u>213-36-4525A</u>		17 INFORMANT <u>George J. Perella, son-in-law</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CVA -</u>										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost		(b) <u>ASCVD -</u>								
		(c) <u> </u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>GASTRIC ENTERITIS DEHYDRATION</u>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>1969</u> P.M. <u> </u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>						
22a I certify that (I) (this hospital) attended the deceased from <u>5-26</u> , 19 <u>69</u> , to <u>5-27</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-26</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>William D. Re...</u>		DEGREE <u> </u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>5-27-69</u>				
22d PHYSICIAN'S NAME (Type) <u>WILLIAM D. RE...</u>		22e ADDRESS <u>ST. AGNES HOSPITAL - 6101 WILKINS HWY.</u>								
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE <u>5/27/69</u>		23c NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>				
24 - FUNERAL DIRECTOR <u>Schmuck Funeral Home</u>		ADDRESS <u>3331 Ashlan</u>		25a REC'D BY REG STRAR <u> </u>		25b REGISTRAR'S SIGNATURE <u>William D. Re...</u>				



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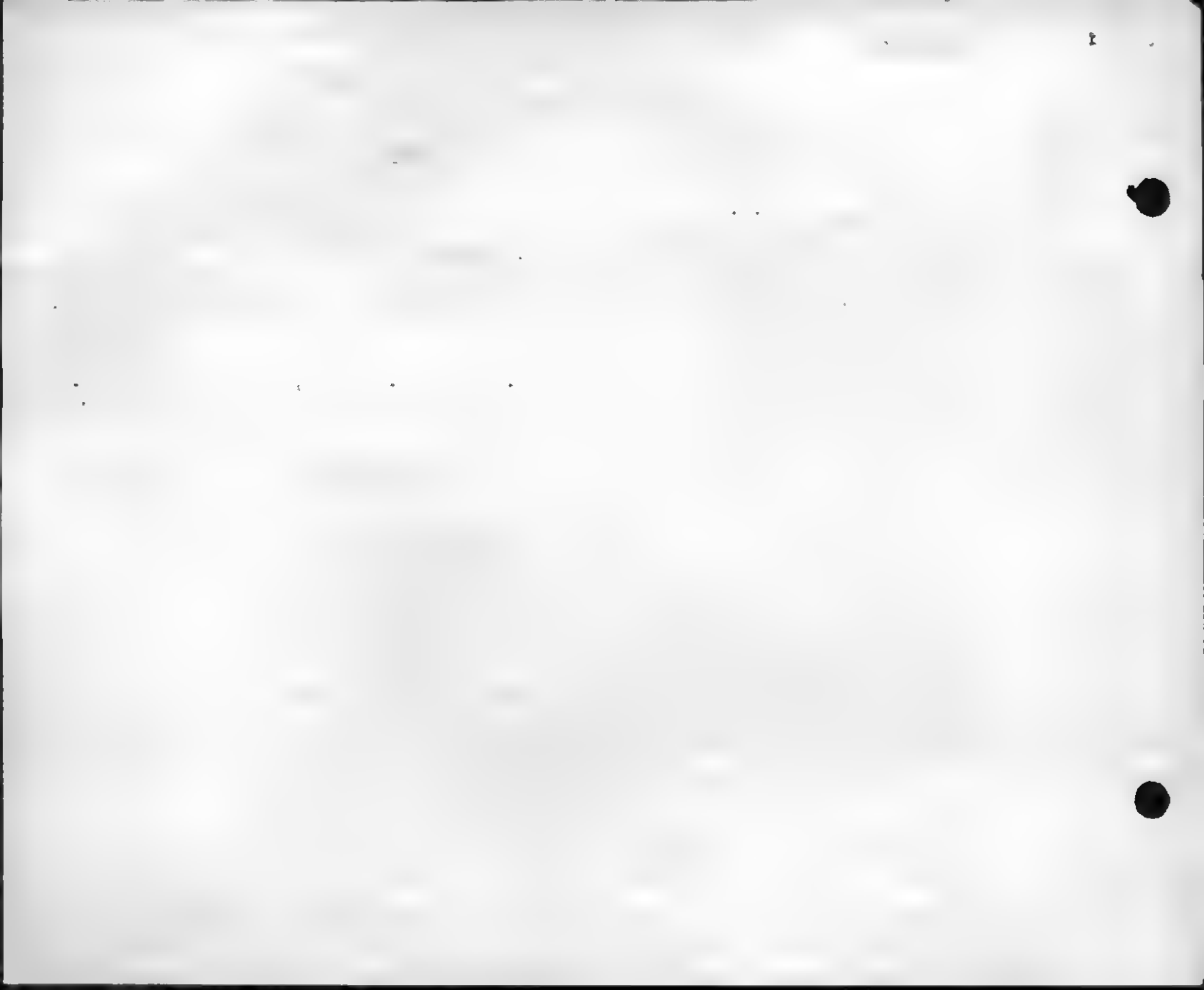
06510

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06508

1 DECEASED NAME (Type or print) First Middle Last Clara Senia Gibson			2a. DATE OF DEATH Month Day Year May 4 1969			2b. HOUR 7:53 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 5/1/1901		6. AGE (In years last birthday) 68 YRS		
7a. BIRTHPLACE (State or foreign country) Europe		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md		
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN 21207		13d. INSIDE CITY CHARTER? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 2204 Maple Hill Ct.			12b. KIND OF BUSINESS OR INDUSTRY AT HOME					
14. FATHER'S NAME First Middle Last Ellis Iskow			15. MOTHER'S MAIDEN NAME First Middle Last Anna ABERMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 216-09-5259		17. INFORMANT MR. ROBERT B. GIBSON, 2204 MAPLE HILL CT. #7			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF <u>cardiac arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 YEARS								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>5-4</u> , 19 <u>69</u> , to <u>5-6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Gus... M.D.</u>			22c. DATE SIGNED 5-6-69			22d. PHYSICIAN'S NAME (Type) A. JELIN A. TORON		
22e. ADDRESS B.C.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-6-69		23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW MEMORIAL GARDENS		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE <u>Gilman, George</u>		



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<div>1</div> <div>06511</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06509</div>														
1 DECEASED-NAME (Type or print)			First MARY		Middle D.		Last GLAZE		2a. DATE OF DEATH Month 18, Day 1969 Year			2b HOUR 10:00 P.M.		
3 SEX Female			4. RACE White			5 DATE OF BIRTH Jan. 25, 1893			6 AGE (in years last birthday) 78 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md		
10. CITY OR TOWN OF DEATH Arbutus			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1171 Linden Avenue			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Arbutus			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1171 Linden Avenue 21227			
14 FATHER'S NAME First Middle Last Jacob Tweedale						15 MOTHER'S M.A.D.E.N. NAME First Middle Last Lucinda Albritten								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or Unknown) (If yes give war or dates of service) No			16b SOCIAL SECURITY NO None			17 INFORMANT Address Mrs. Carma Yeager, 1171 Linden Avenue 21227								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Carcinoma</u> 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) <u>General Carcinomatosis</u> last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>2nd</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION <u>Apr 27/69</u>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Exploratory Laparotomy</u>			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 27</u> , 19 <u>69</u> , to <u>May 18</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (aid not) view the body after death.														
22b SIGNATURE <u>Dr. Bruce Brumbaugh</u>			22c DATE SIGNED <u>5/20/69</u>			22e ADDRESS 5609 Main Street, Elkridge, Maryland								
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 5-21-1969			23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d LOCATION (City or Town) (County) (State) Ritchie Hwy., Balto. Co., Md.					
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			25a REC'D BY REGISTRAR DATE MAY 22 1969			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

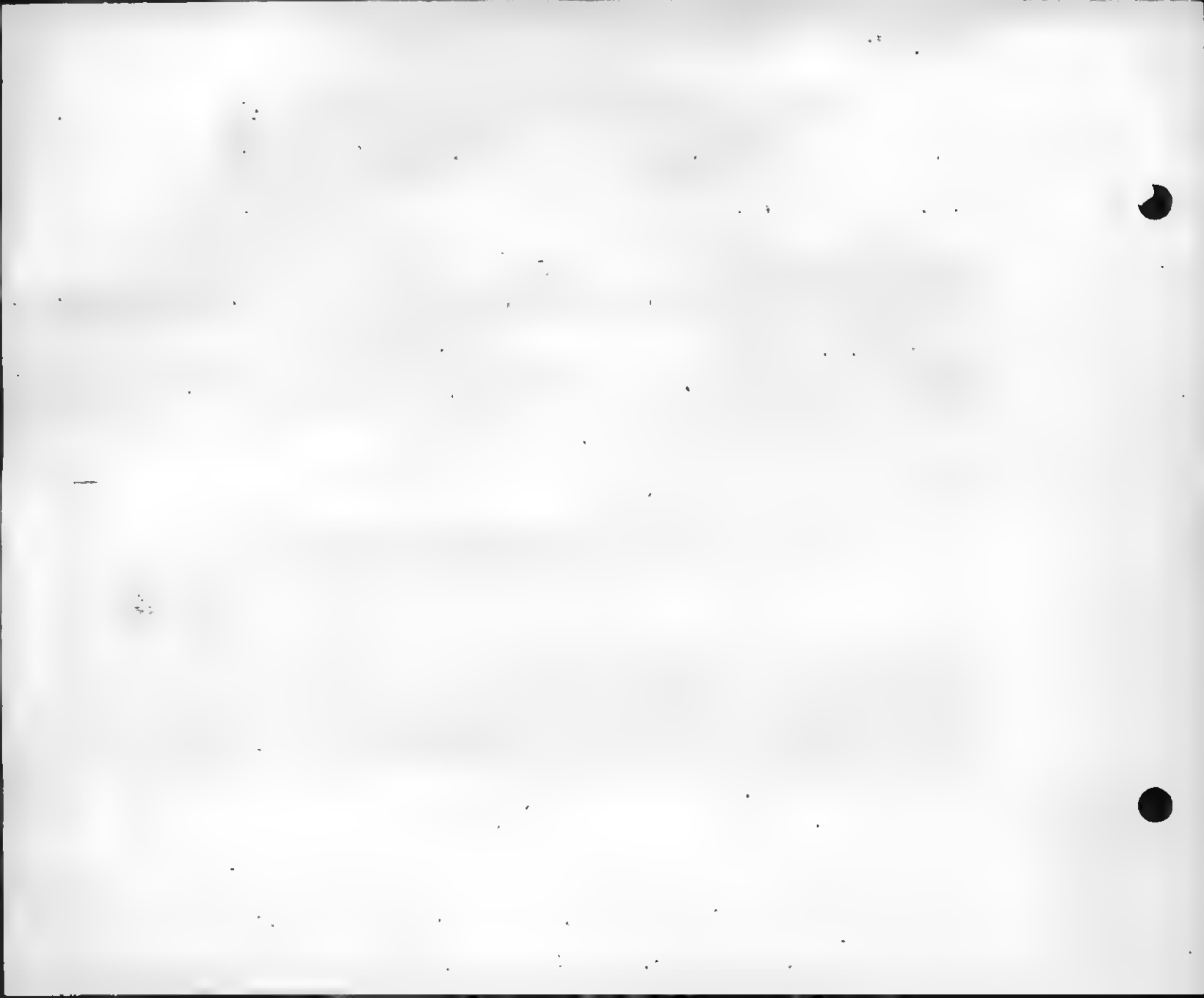


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VR A15
30M REV 68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
06512										
06510										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR A		
Matilda Elizabeth Gleitsmann						May 9, 1969		5.53 M		
3 SEX		4. RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
F.		White		Aug. 19, 1916		52 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		U.S.A.				Baltimore		Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				
Timonium			2446 Spring Lake Drive			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Timonium		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2446 Spring Lake Drive	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
John G.A. Damm				Elizabeth Hagen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT				
No				1-99-27-4265		Mr Carl O. Gleitsmann 2446 Spring Lake Drive				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure										
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis									6 months	
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the breast									4 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from May 12, 1969, to May 9, 1969, that (I) (we) last saw the deceased alive on May 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Donald O. Wood						22c. DATE SIGNED 5-9-69				
22d. PHYSICIAN'S NAME (Type) DONALD O. WOOD, M.D.						22e. ADDRESS York Road and Greenmeadow Drive				
23a. BURIAL, CREMATION, OR OTHER DISPOSAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		May 12, 1969		Loudon Park Cemetery		Baltimore Maryland				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Henry Sander & Sons Inc. Baltimore MD.				MAY 13 1969						

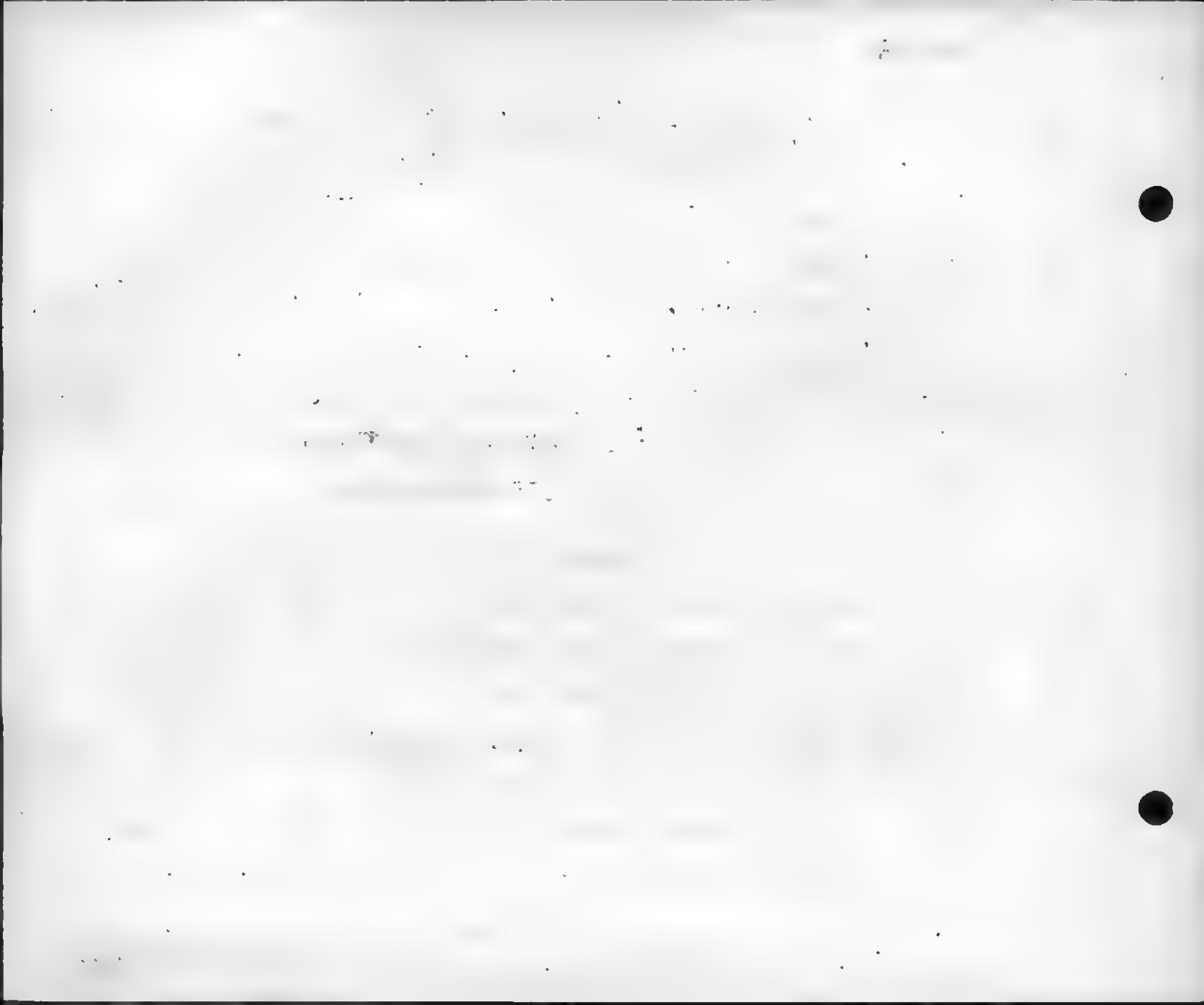


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
M REV. 1/60

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR 10 ¹⁵ AM				
Dr. M. John Cantius Gluck						5 18 69							
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN		
Female		White		1-4-1885			84 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Penn.			U.S.A.						Baltimore			Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Glen Arm			Villa Maria, Glen Arm			Teacher							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
Md.			Baltimore			Glen Arm			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Glen Arm, Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
Charles Gluck			Josephine Kreiss										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address				
no			205-40-3304			R. M. Kathleen P. N.			Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure & Nephrosis													
DUE TO, OR AS A CONSEQUENCE OF (b) Kimmelsteil Wilson Disease													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Hat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from October 20, 1966, to March 20, 1969, that (I) (we) last saw the deceased alive on March 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED										
Henry L. McEckle			5-19-69										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
HENRY L. MCECKLE MD			Phoenix, Maryland 21131										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			5-20-69			SISTERS CEMETERY			Glen Arm Baltimore Md.				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
RAYMOND CURRAN			MAY 22 1969			Charles Judge							



1541

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 45M

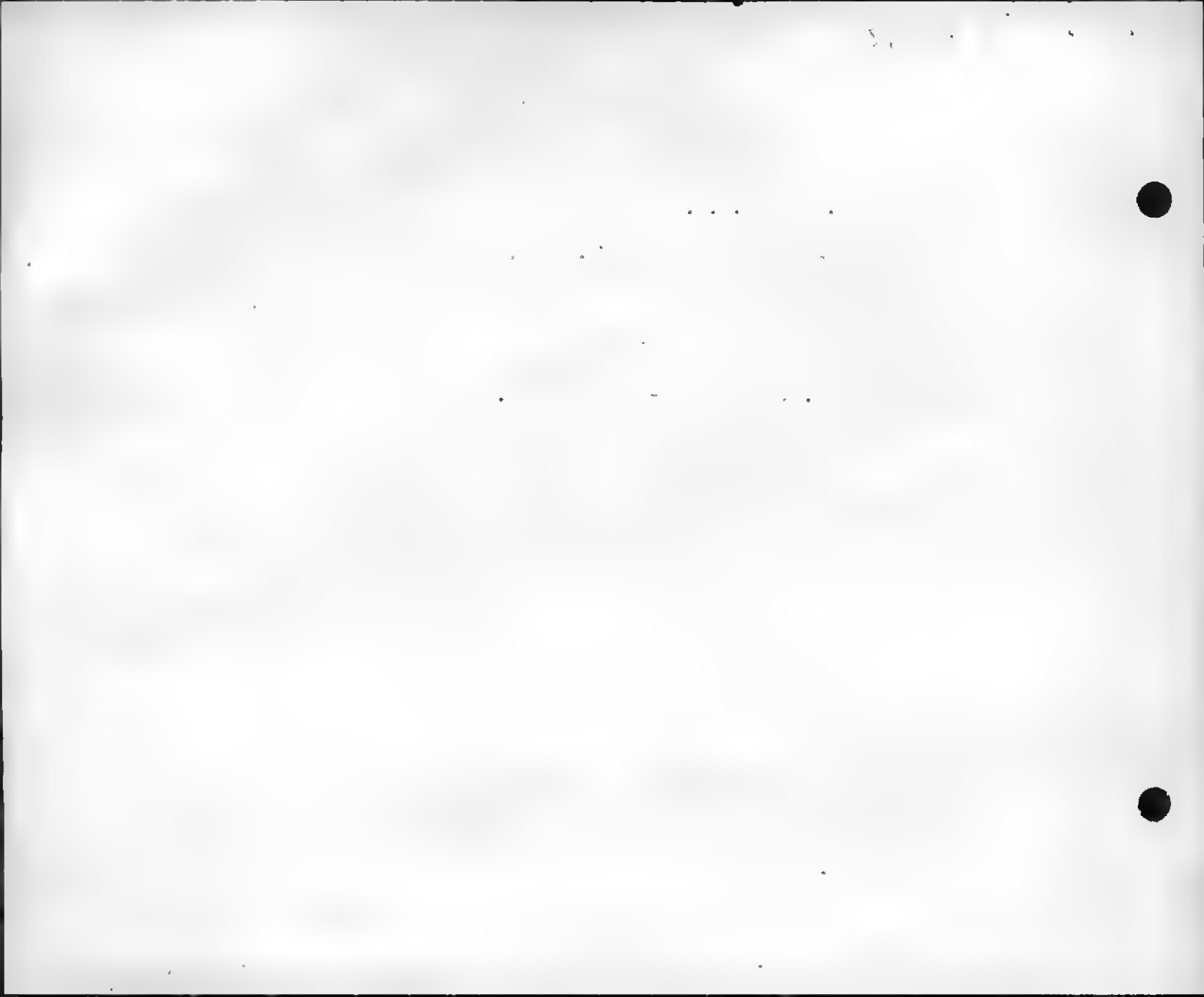
06514

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06512

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
HARRY			NMN	GOODMAN	05 Month 20 Day 69 Year 11		3:32 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	7. UNDER 1 YEAR		8. UNDER 24 HRS
MALE	XXX WHITE		05-15-04		65 YRS	MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
BALTIMORE, MD.		U.S.A.				BALTIMORE COUNTY Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
TOWSON, MD.		GRTR. BALTO. MED. CNTR				TRAFFIC MANAGER - AMERICAN ICE CO.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
MARYLAND				BALTIMORE		2607 W. BELVEDERE AVENUE		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
DAVID				FOODMAN	REBECCA URETSKY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address				
YES		W.W. 11		214-01-5223 MRS. ELSIE SHUGAR, 3410 WOODVALLEY DRIVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION								IMMEDIATE
1541 DUE TO, OR AS A CONSEQUENCE OF (b) CA OF RECTUM								4 MONTHS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
05-20-69		CA OF RECTUM		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 05-16, 19 69, to 05-20, 19 69, that (I) (we) last saw the deceased alive on 05-20, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED
B.R. Choi M.D.								05-20-69
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
B.R. CHOI M.D.				6701 NORTH CHARLES STREET				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		5-22-69		SHAAREI ZION		ROSEDALE, MARYLAND		
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				MAY 26 1969		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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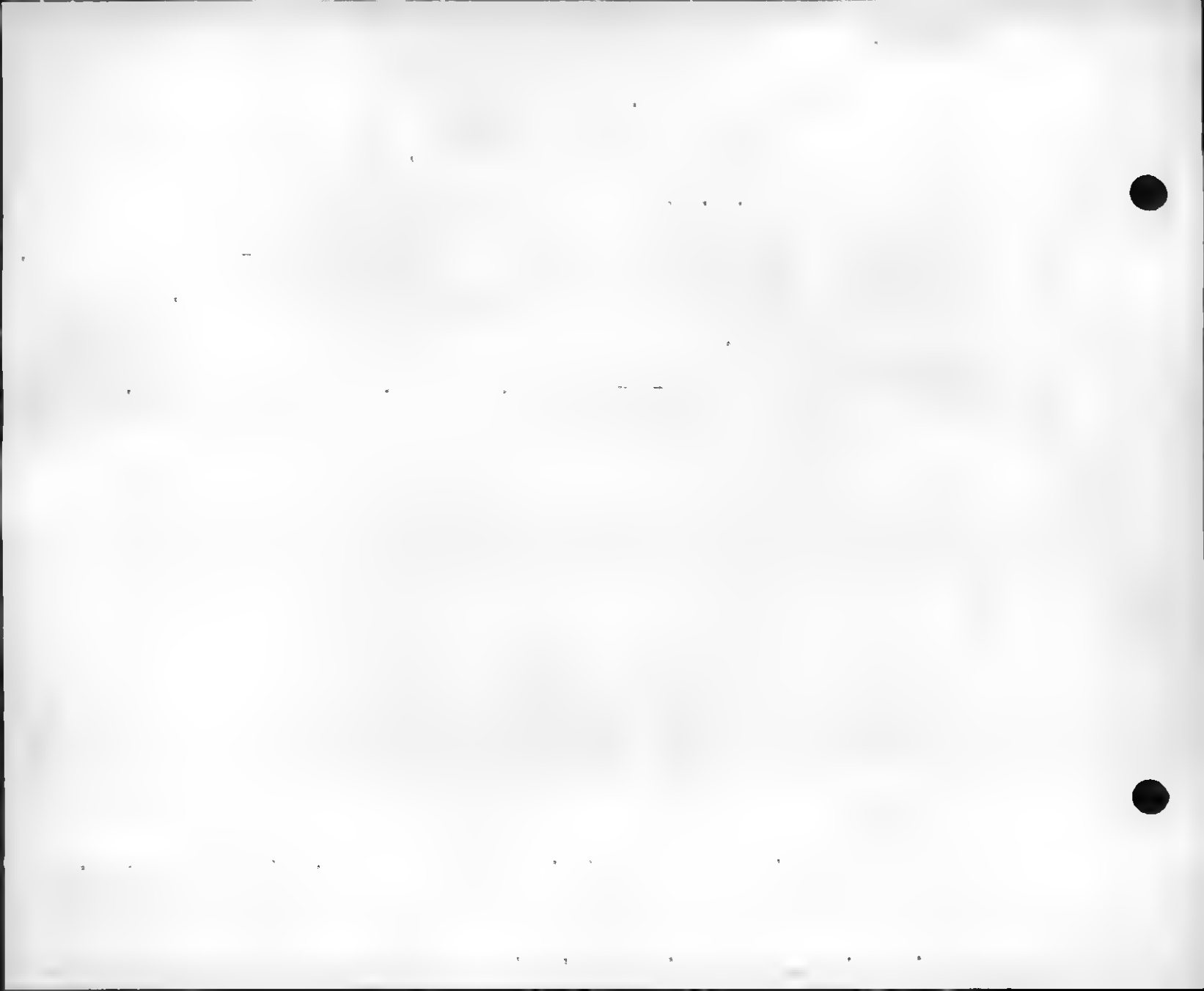
06515

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06513

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) George		First S.		Middle Goudy		Last Goudy		2a DATE OF DEATH Month May Day 11 Year 1969			2b HOUR M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH March 24, 1916			6 AGE (In years last birthday) 53 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore			Md.			
10 CITY OR TOWN OF DEATH Edgemere			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7326 Geis Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Shipping Clerk-Arcrods			12b. KIND OF BUSINESS OR INDUSTRY Welding Co.			
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Edgemere		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 7326 Geis Ave.			
14 FATHER'S NAME First Notley Middle A. Last Goudy			15 MOTHER'S MAIDEN NAME First Jessee Middle Brown Last Brown									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No, or unknown <input type="checkbox"/> WWII			16b SOCIAL SECURITY NO 216-01-3887		17 INFORMANT (Wife) Mrs. Dortha A. Goudy, 7326 Geis Ave.			Address Edgemere, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Colon 1597 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1+ yrs.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.O. No City or Town County State						
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE Louis O. Olsen						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED 5/12/69			
22d PHYSICIAN'S NAME (Type) Louis O. Olsen						M. D.			22e ADDRESS 914 "D" Street, Sparrows Point, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 5/14/69		23c NAME OF CEMETERY OR CREMATORY Lantzride Cemetery			23d LOCATION (City or Town) (County) (State) Preston Co. West Virginia				
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						ADDRESS			25a RECD BY REGISTRAR DATE MAY 14 1969		25b REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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06516

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06514

1. DECEASED NAME (Type or print) WILLIAM R. B. GOULD		2a. DATE OF DEATH 05 Month 14 Day 69 Year 12:55 AM	
3 SEX MALE	4 RACE CAU	5 DATE OF BIRTH 6-15-25-	6 AGE (n years, m months, d days) 43 YRS.
7a BIRTHPLACE (State or foreign country) Minnesota	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE CO.
10. CITY OR TOWN OF DEATH TOWSON, MD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GRTR. BALTO. MED. CENTER	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Lumber Salesman	12b. KIND OF BUSINESS OR INDUSTRY Lumber
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Md.	13b COUNTY Balto.	13c CITY OR TOWN Cookeysville	13d INSIDE CITY, Y.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last Robert B. Gould		15 MOTHER'S MAIDEN NAME First Middle Last Louise Martin	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)	16b SOC AL SECURITY NO 215 24 8590	17 INFORMANT Address Robert B. Gould 1118 Stevenson Lane	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENO CA OF THE STOMACH WITH GENERAL METASTASIS 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC	21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from FEB. 10, 1969 , to MAY 14 , 19 69 , that (I) (we) last saw the deceased alive on MAY 13 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE Mary O. Lim M.D. DEGREE M.D.		22c DATE SIGNED MAY 14, 1969	
22d PHYSICIAN'S NAME (Type) DR. MARY O. LIM		22e ADDRESS 6701 NORTH CHARLES ST.	
23a BURIAL, CREMATON, REMOVAL (Specify) Burial	23b DATE 5/16/69	23c NAME OF CEMETERY OR CREMATORY Dulaney Valley Gardens Cemt. Cookeysville Balto. Md.	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd.		25a REC'D BY REGISTRAR DATE MAY 19 1969	25b REGISTRAR'S SIGNATURE [Signature]



1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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06517

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06515

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
MAMIE			GREENBERG.			Month Day Year			12 35 PM		
3 SEX			4 RACE			5 DATE OF BIRTH			6. AGE (In years last b./rthday)		
FEMALE			WHITE			1898 JULY 22 - 1928			70 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
BALTO. PA , MD.			USA						BALTIMORE, COUNTY Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
RANDALLSTOWN			BALTO. COUNTY GEN HOSP			SEAMSTRESS. CLOTHING MANUFACTURING					
13a. USLA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY L.M. IS?		
MARYLAND			BALTIMORE			BALTIMORE			NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		
JACOB			HENRIETTA ?			NO			223-01-7281		
17 INFORMANT			Address			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MRS. LENORE GINSBERG, 3408 DEEPWILLOW AVE. #8						PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u>			TERMINAL		
						(b) <u>Ca g lung = metastasis</u>			Rupture -		
						(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
Cerebrovascular accident - Old small infarct of cerebellum											
20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY		
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			yes						HOUR A.M. Month Day Year		
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION		
			While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>May 20</u> , 19 <u>69</u> , to <u>May 23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 23</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE			22c. DATE SIGNED					
			NIEVA G. VALLE			May 23, 1969.					
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22f. DATE SIGNED			22g. REGISTRAR'S SIGNATURE		
NIEVA G. VALLE			BALTIMORE COUNTY GENERAL HOSPITAL						Charles Judge		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			5-25-69			CHIZUK AMUNO			BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			MAY 27 1969								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06518

CERTIFICATE OF DEATH

06516

1 DECEASED NAME (Type or print) First Middle Last JOHN JOSEPH GROSKI			2a. DATE OF DEATH Month Day Year MAY 3, 1969		2b. HOUR 11:15 AM
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH AUGUST 11, 1907		6. AGE (in years last birthday) 61 YRS	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md		
10. CITY OR TOWN OF DEATH TOWSON 21204		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Boiler Maker-Beth.	
13a. USUAL RESIDENCE (Where deceased addressed) STATE MARYLAND		13b. COUNTY BALTIMORE	13c. INS OF CITY, TOWN, OR VILLAGE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER 3441 FLORA AVENUE, 21213	
14. FATHER'S NAME First Middle Last George Greoski		15. MOTHER'S M A DEN NAME First Middle Last Mary Machinski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO 205-05-2980		17. INFORMANT Address Margaret (nee Stickler) wife, above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma of the colon DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (a) (this hospital) attended the deceased from March 29, 1969, to May 3, 1969, that (b) (we) last saw the deceased alive on May 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lucas Vidhyaphan M.D.		22c. DATE SIGNED May 3, 1969		22d. PHYSICIAN'S NAME (Type) Lucas Vidhyaphan M.D.	
22e. ADDRESS 7620 York Road, Towson 4, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/7/69		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)			
24. FUNERAL DIRECTOR Schimunek Funeral Home		ADDRESS 3331 Brehmstown		25a. RECEIVED BY REGISTRAR MAY 7 1969	
25b. REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 hours after death. Page 4 may be retained by the hospital or attending physician.

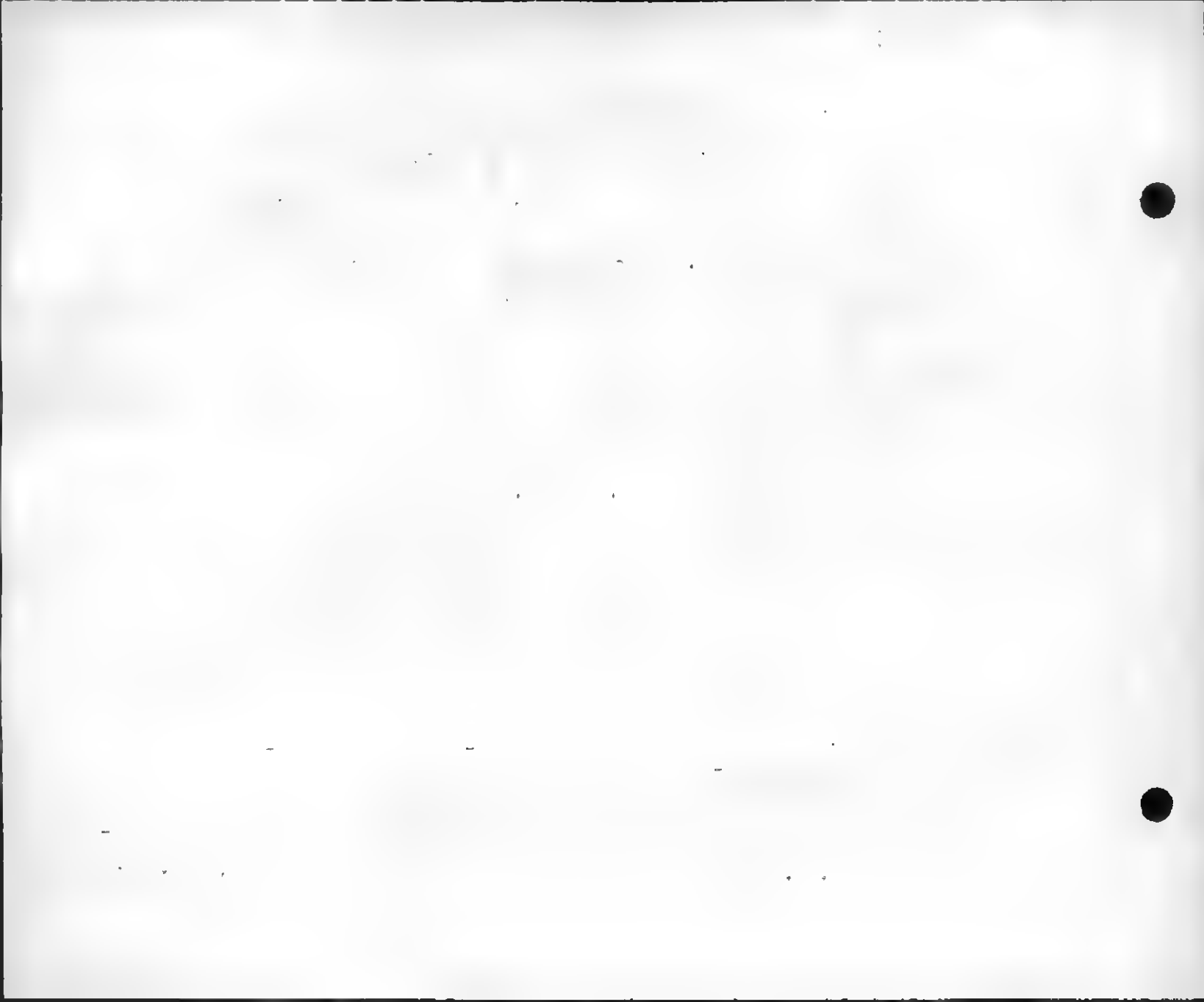
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06519

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06517

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR P		
Anna Bertha Grill					May 4 1969		2:55 M		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		
Female	White		5-14-90		78 YRS				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore		USA				Baltimore Md			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INST TUT ON (If not a hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. K IND OF BUSINESS OR INDUSTRY			
Baltimore		St. Joseph Hospital		Homemaker					
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d. INSIDE CITY (UM TS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland				Baltimore				2901 Echodale Avenue #21214	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
Conrad				Merz	Margaret				?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
No		213-05-1787 D		Daughter- Leona Joynes - same as patient					
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Gastro-intestinal Bleeding</u>									
5310 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Gastric Ulcer</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Multiple Myeloma</u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year							
(If either, notify medical examiner)		P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		City or Town County State			
While <input type="checkbox"/> Not while <input type="checkbox"/>				Street or R.F.D. No					
at work <input type="checkbox"/> or work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> , 19 <u>69</u> to <u>5-4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-4</u> , 19 <u>69</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d ADDRESS		22e. DATE SIGNED			
<i>Dr. L. Cilliani</i>		Dr. L. Cilliani		7620 York Road, Towson, Maryland 21204		5-5-69			
23a BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/8/69.		Holy Redeemer Cemetery		Baltimore, Md.			
24 FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG. STRAR DATE		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc. Balto. Md.				MAY 8 1969		<i>Michael V. Walsh</i>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
10M REV. 1/64

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06518

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR
Albert		A.		Groth Jr.	5-10	69	-	M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	MIN	2c DATE PRONOUNCED DEAD	Month	Day
Male	White	July 21, 1912	56 YRS				May	11	19 69
7a BIRTHPLACE (State or foreign country)	7b CIT ZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH						
Maryland	U. S. A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore						
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY						
Jones Creek	7201 Bucher Road	Ship Fitter-Bethlehem Steel Co.							
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INS DE CITY LIMTS?	13e STREET AND NUMBER					
Maryland	Baltimore	Dundalk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	8217 Rosebank Ave.					
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last		
Albert A.			Groth Sr.	Augusta			Koenig		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO (If yes give war or dates of service)	17 INFORMANT (Wife)	ADDRESS Dundalk, Md.						
No	213-07-1924	Mrs. Myrtle E. Groth, 8217 Rosebank Ave.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
	19	Apparently jumped into water @ Annapolis river							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.O. No. City or Town County State							
	John Creek	Rocvic Court 1d - Spot - Balto - 19 - Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 5/12/69		
EXAMINER'S NAME (Type)		Melvin B. Davis			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6800 Morningson Rd.		
		M.D.			ADDRESS(Street, city, town, or county)		Dundalk, Md. 21222		
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial	5/14/69	Oak Lawn Cemetery			Baltimore, Maryland				
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
John J. Duda, 7922 Wise Ave. Dundalk, Md.					MAY 14 1969				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06521

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

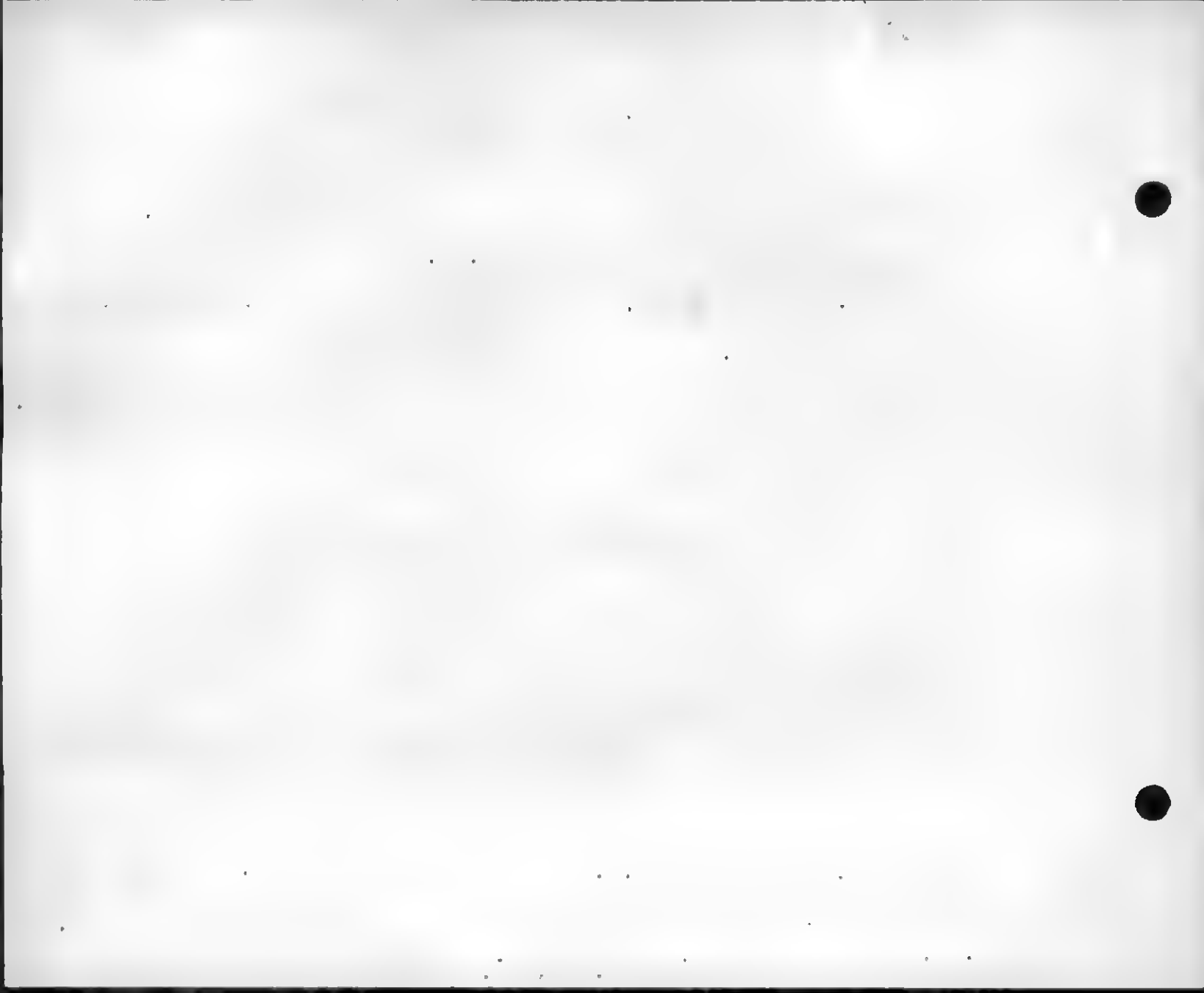
06519

Item 13 File 10412 5/19/69 kk

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Grace C. Grove			2a DATE OF DEATH Month Day Year May 9 69		2b HOUR 4:45 PM
3 SEX F	4 RACE W	5 DATE OF BIRTH 8-1-86		6 AGE (In years last birthday) 82 YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Co. Md.		
10 CITY OR TOWN OF DEATH Towson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor N. H. School Teacher		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b CITY OR TOWN Baltimore	13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d STREET AND NUMBER 1506 Pentridge Rd. Apts.		
14. FATHER'S NAME First Middle Last Thomas C. Grove		15. MOTHER'S MAIDEN NAME First Middle Last Alice Boardman			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Miss Margaret Grove 11 Guernsey St. Marble Head, Mass.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of the breast 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. ex. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from January, 1967 , to May 9, 1969 , that (I) (was) last saw the deceased alive on Apr 30 19 69 , and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.					
22b. SIGNATURE A. Allen Spier M.D.		22c. DATE SIGNED 5/12/69		22d. PHYSICIAN'S NAME (Type) A. Allen Spier M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-12-69		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	
23d. LOCATION (City or Town) (County) (State) Baltimore 21208 Md.		24. FUNERAL DIRECTOR H. W. Jenkins Sons Co. 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR MAY 12 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge					

VR AIS 45M - 106



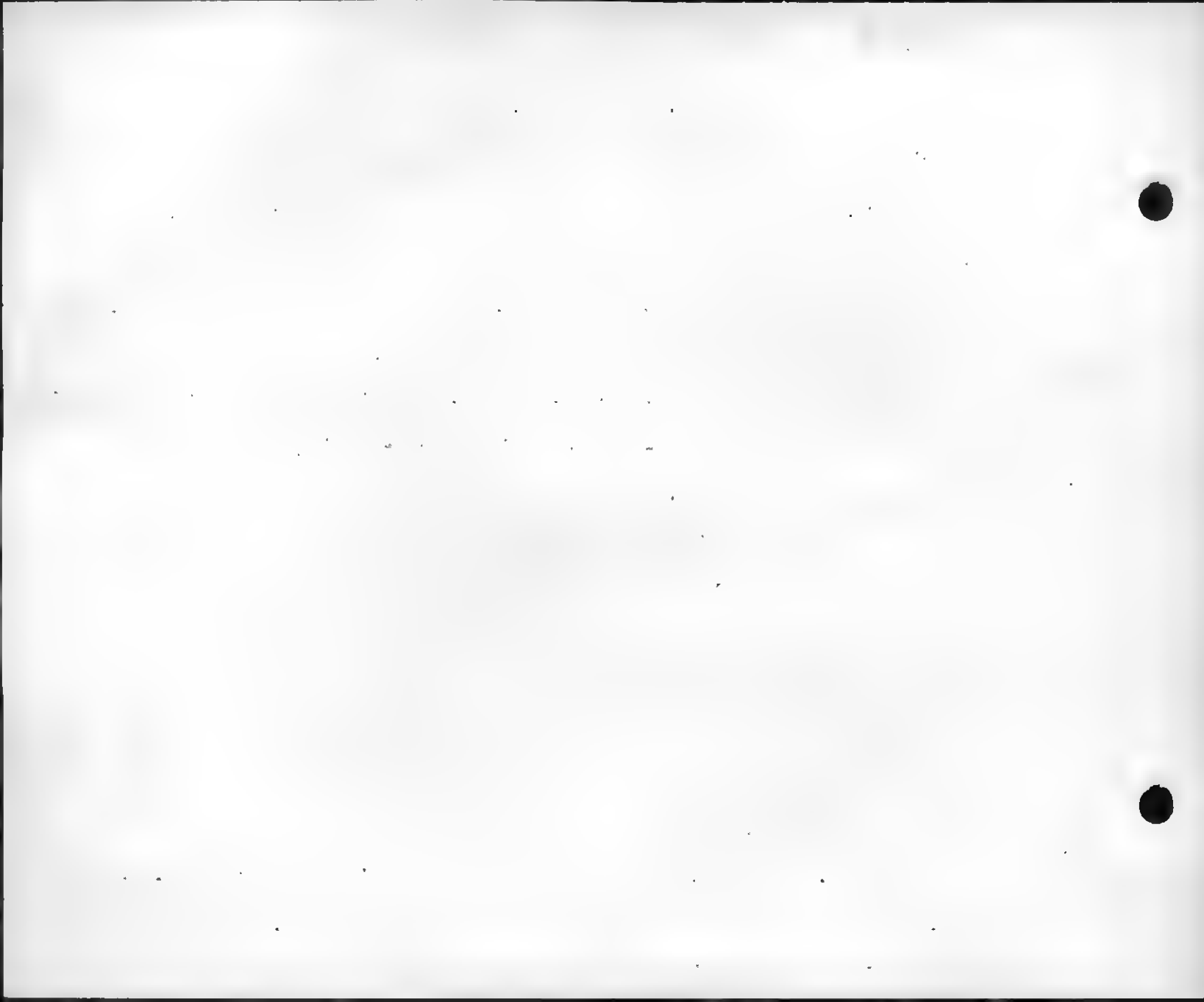
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15
30A REV

<div style="display: flex; justify-content: space-between;"> 06522 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06520 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>																				
1 DECEASED NAME (Type or print)			First Theresa			Middle A.			Last Haberborn			2a DATE OF DEATH Month 5 Day 13 Year 69			2b HOUR 1:20 PM					
3 SEX Female			4 RACE White			5. DATE OF BIRTH 3/27/1897			6 AGE (In years last birthday) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN						
7a. BIRTHPLACE (State or foreign country) Baltimore			7b CITIZEN OF WHAT COUNTRY? United States			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore County Md.											
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stella Maris Hospice			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) salad maker			12b KIND OF BUSINESS OR INDUSTRY											
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland			13b. COUNTY Baltimore			13c CITY OR TOWN Baltimore			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER 3009 Lavender Ave.								
14. FATHER'S NAME First Middle Last Adam John Haberborn						15 MOTHER'S MAIDEN NAME First Middle Last Theresa Schnreiter														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO. 213-14-0321			17. INFORMANT Address Stella Maris Hospice, Dulany Valley Rd.														
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:																				
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>																				
DUE TO, OR AS A CONSEQUENCE OF																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																				
(b) <u>Generalized arteriosclerosis</u>																				
DUE TO, OR AS A CONSEQUENCE OF																				
(c) <u>Diabetes mellitus</u>																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Severe arterial + venous insufficiency 2° to b) + c)</u>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
2 d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No. City or Town County State														
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b SIGNATURE <u>E. Lea Robbins</u>															DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 5/13/69	
22d. PHYSICIAN'S NAME (Type) E. Lea Robbins						22e ADDRESS 312 Mockingbird Lane Balto. Md 21201														
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/17/69			23c NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			23d LOCATION (City or Town) (County) (State) Baltimore, Md.											
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						ADDRESS			25a. REC'D BY REGISTRAR DATE MAY 14 1969			25b REGISTRAR'S SIGNATURE								

MEDICAL CERTIFICATION

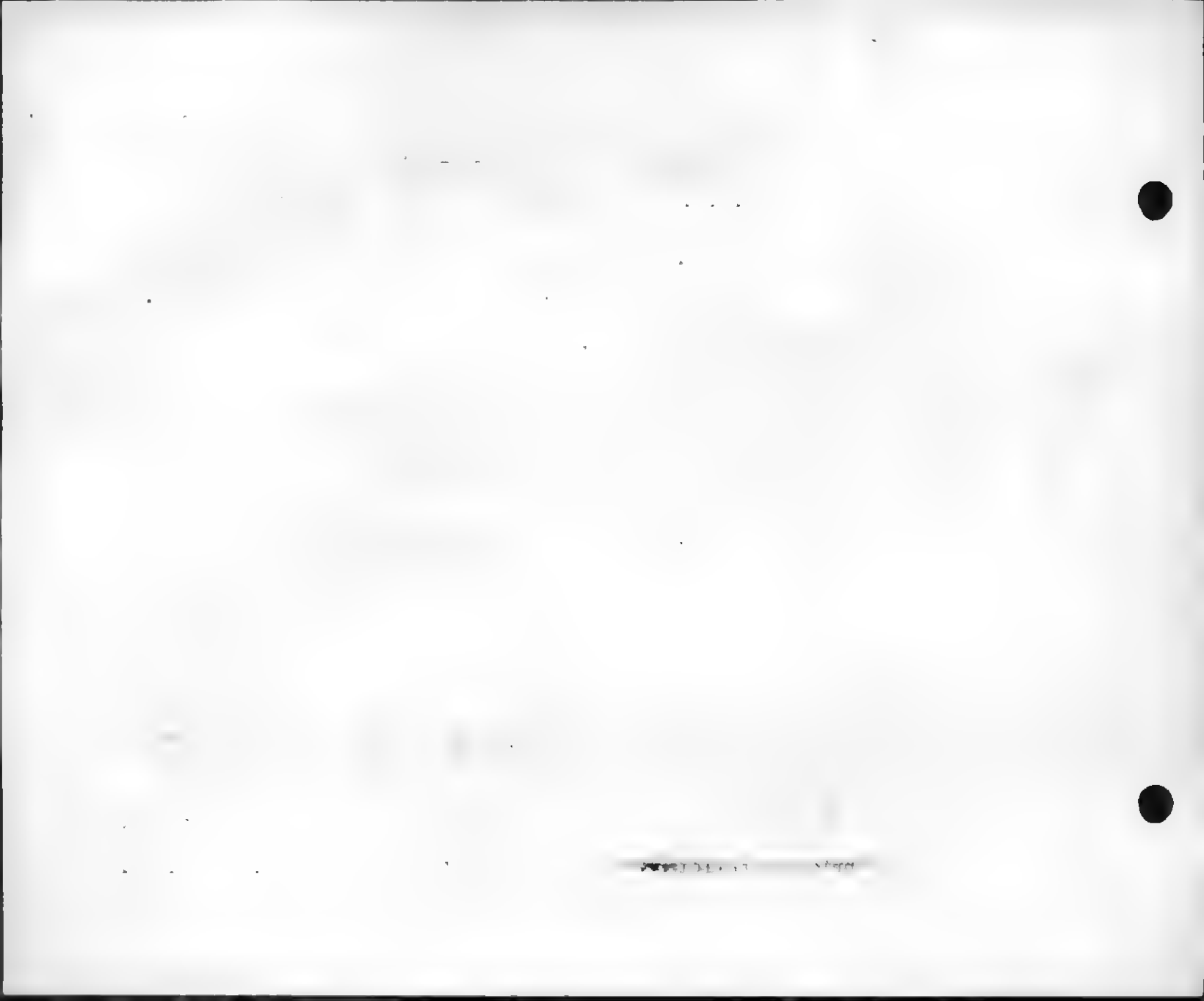


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
THOMAS				HANKINSON		JR		MAY 17, 1969	
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		2b. HOUR	
MALE		WHITE		8-15-1904		64 YRS		1 p.m.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
England		U.S.A.				BALTIMORE		Retired	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. SOCIAL OCCUPATION (Kind of work done during most of working life, even if retired)					
TOWSON #4		ST. JOSEPH HOSPITAL		Shipyard worker					
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTIMORE		Perry Hall		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4224 Chapel Rd. #21128	
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Thomas		Hankinson		Sr.				Rosella Warnes	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
No		017-14-3482		HOSPITAL RECORDS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory insufficiency									
485X DUE TO, OR AS A CONSEQUENCE OF bronchopneumonia and									
DUE TO, OR AS A CONSEQUENCE OF pulmonary congestion and edema.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 12, 1969, to May 17, 1969, that (I) (we) last saw the deceased alive on May 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME		22e. ADDRESS			
Christina Feliciano, M.D.		May 17, 1969		Christina Feliciano, M.D.		7620 York Road, Towson #4, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		1969-MAY-20		PARKWOOD CEMETERY		BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Dippel Bros. Inc.		7110 BELAIR ROAD		MAY 20 1969		[Signature]			



FOR STATE
HEALTH DEPT.

06524

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

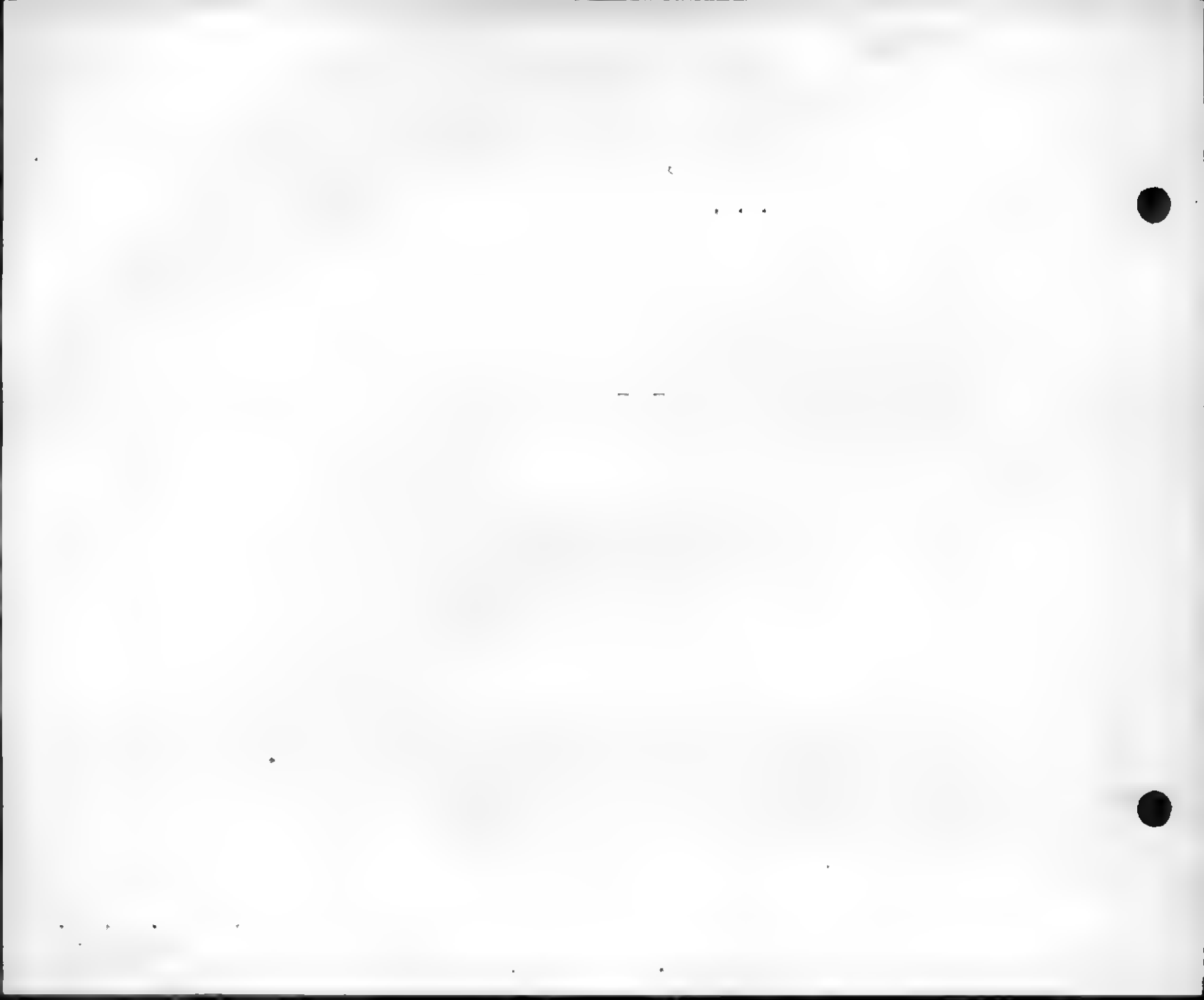
06522

1 DECEASED NAME (Type or Print) Bertram ^{First} S. ^{Middle} HARE ^{Last}		2a DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 5-22 1969 8:30 PM		2b HOUR
3 SEX Male	4 RACE White	5 DATE OF BIRTH March 21, 1902 67 YRS	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Md
10 CITY OR TOWN OF DEATH Baltimore County		11 NAME OF HOSPITAL OR INSTITUTION (if not in hosp to give street address) Balt. General Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Housing Authority
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md.		13b COUNTY Baltimore	13c CITY OR TOWN Rockdale	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME First Walter Middle Hare Last		15 MOTHER'S M A D E N NAME First Delila Middle Beaver Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO 216-09-8990		17 INFORMANT ADDRESS wife: Mrs Margaret Hare (same address)
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obesity - extreme DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH None
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION 5-23-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year 19 HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Robert B. Taylor MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 5-23-69
EXAMINER'S NAME (Type) Robert Bruce TAYLOR		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
		ADDRESS (Street, city, town, or county) 700 Cathedral St Balt.		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE May 26, 69	23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d LOCATION (City or Town) Liberty Rd. Balto, Co, Md.	(County) (State)
24 FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown		25a REC'D BY REG STRAR MAY 26 1969		25b REGISTRAR'S SIGNATURE W. Charles Judge

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06525

CERTIFICATE OF DEATH

06523

1. DECEASED-NAME (Type or print) GILLEN GORDON HARPER		2a. DATE OF DEATH Month 5 Day 5 Year 69		2b. HOUR 3:50 PM
3 SEX Male	4 RACE White	5. DATE OF BIRTH 4-28-1906		6 AGE (In years last birthday) 63 YRS.
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County, Md	
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Mt. Wilson State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Balto	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last JOHN F. HARPER		15. MOTHER'S MAIDEN NAME First Middle Last CORILLA CHRISTOPHER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 212-03-9123		17. INFORMANT Address Records, Mt. Wilson State Hospital
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuber- culosis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic heart disease				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 8-16 , 19 66 , to 5-5 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE W. Newcomer				22c. DATE SIGNED 5-5-1969
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS Mount Wilson, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-8-69	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		23d. LOCATION (City or Town) (County) (State) Howard Co., Maryland
24. FUNERAL DIRECTOR George J. Gonce Home		ADDRESS 4001 Ritchie Hgy. 21225		25a. REC'D BY REGISTRAR MAY 12 1969
				25b. REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

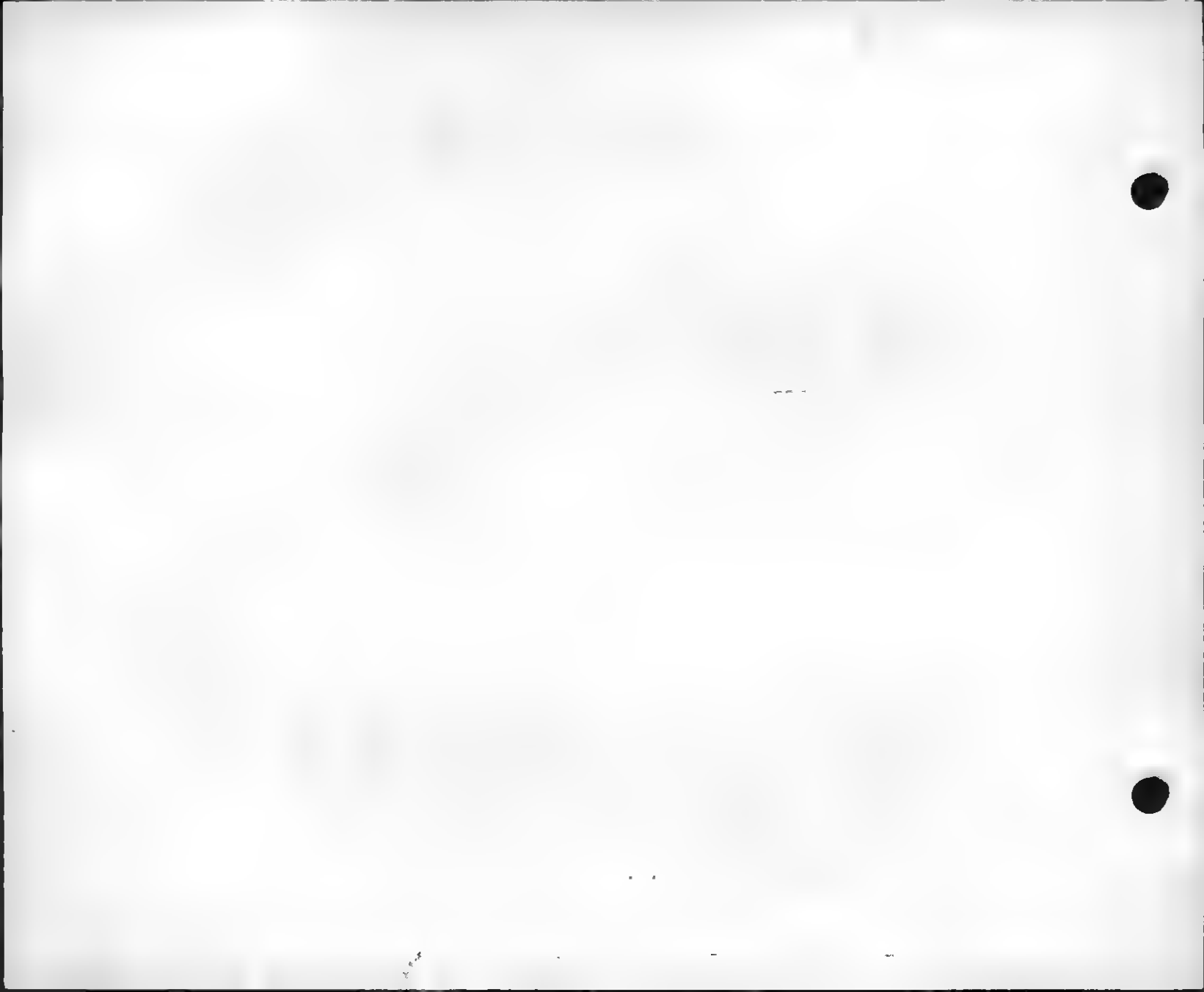
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06526

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06524

1 DECEASED-NAME (Type or print) EUGENIA			First D			Middle HART			Last			2a DATE OF DEATH Month 5 Day 15 Year 69			2b HOUR 1:19 PM																																																								
3 SEX FEMALE			4 RACE WHITE			5 DATE OF BIRTH APRIL 25, 1911			6 AGE (In years lost birthday) 58 - YRS.			F UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.																																																								
7a BIRTHPLACE (State or foreign country) U.S.			7b CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH BALTIMORE Md																																																														
10 CITY OR TOWN OF DEATH TOWSON						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DULLANEY-TOWSON Nursing Home						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WIFE						12b KIND OF BUSINESS OR INDUSTRY																																																					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.						13b COUNTY BALTO.						13c CITY OR TOWN TOWSON						13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e STREET AND NUMBER 3915 BEECH AVE. 21211																																															
14 FATHER'S NAME First Thomas O. Jones									Middle									Last									15. MOTHER'S MAIDEN NAME First Theresa A. Hedges									Middle									Last																										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service) ---																		16b SOCIAL SECURITY NO ---																		17 INFORMANT DULLANEY-TOWSON Nursing Home																		Address TOWSON, MD. 111 WEST Rd.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) encephalomalacia DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yr.																																																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																							
19a DATE OF OPERATION												19b CONDITION FOR WHICH OPERATION WAS PERFORMED												20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>												20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)												21b TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.												21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																															
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>												21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.												21f LOCATION Street or R.F.D. No City or Town County State																																															
22a. I certify that (I) (this hospital) attended the deceased from DEC. 1 , 19 68 , to MAY 15 , 19 69 , that (I) (we) last saw the deceased alive on JAN. 8 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																																																																							
22b SIGNATURE Joseph D.B. King, M.D.																		DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>																		22c DATE SIGNED 5-19-69																																			
22d. PHYSICIAN'S NAME (Type) Joseph D.B. King, M.D.																		22e ADDRESS 2 Hamill Rd. Cross Keys																																																					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial												23b DATE 5/19/69												23c NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery												23d LOCATION (City or Town) (County) (State) Baltimore																																			
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd. 21212																		ADDRESS																		25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE J. J. J. Judge																									
DATE MAY 22 1969																																																																							

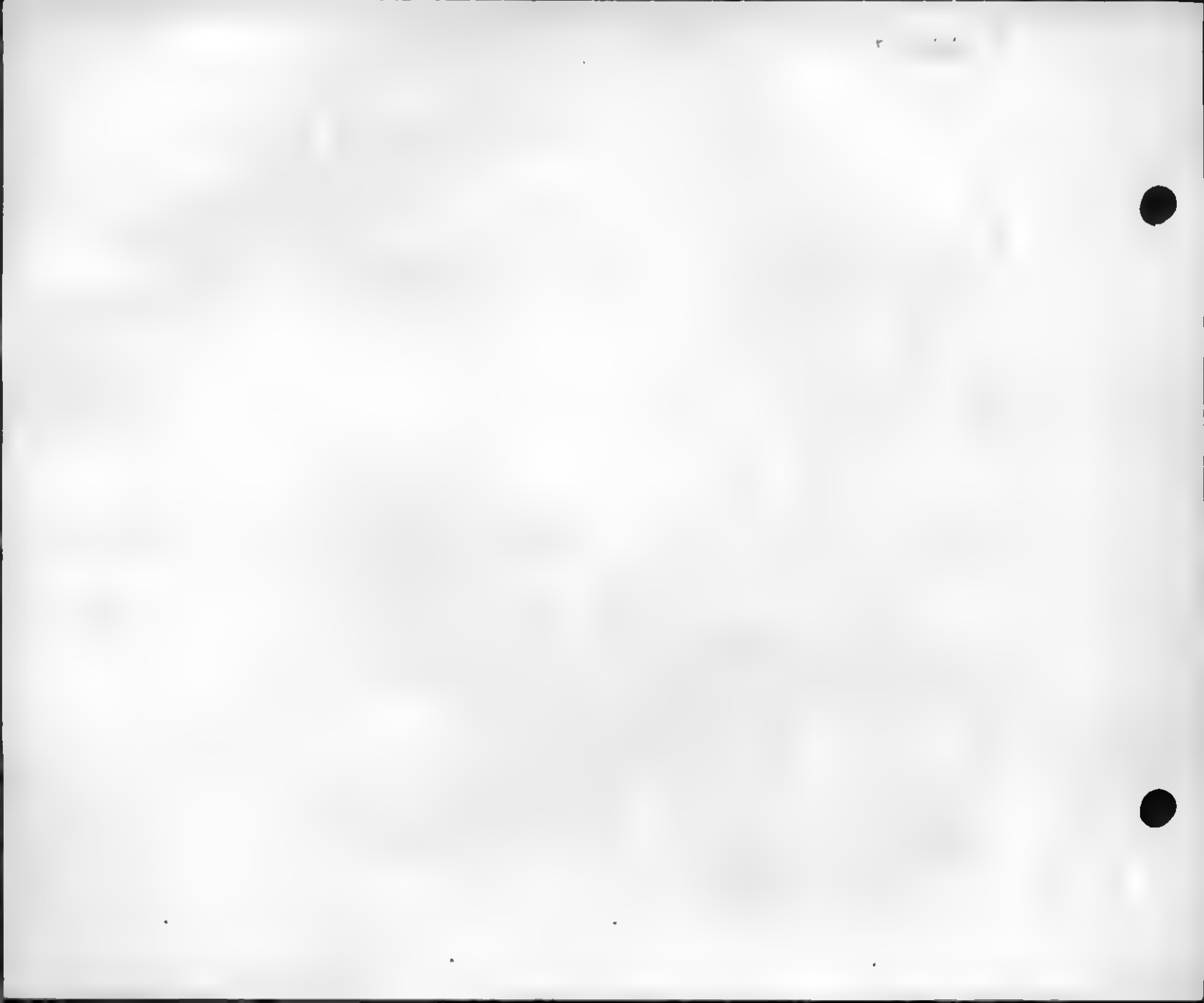


FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06525			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										06525			
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF EST. DEATH		2b HOUR		
GEORGIA					HARVEY				Month 5 Day 9 Year 1969		1230 M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD	
F		COL		2		28 YRS		MONTHS DAYS		HOURS MIN.		Month 5 Day 9 Year 1969	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			2d HOUR	
MD.			USA						BALTO.			1605 M	
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
CATONSVILLE				O				not working				O	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE				13b COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e STREET AND NUMBER			
MD.				BALTO.		CATONSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		#6 DUNBAR AVE.			
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First	
NOT			KNOWN						NOT			KNOWN	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17. INFORMANT				ADDRESS	
O				Z15-16-0873				JARRIE HARRIS				SAME	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:										5 DAYS			
IMMEDIATE CAUSE (a)										CVA			
DUE TO, OR AS A CONSEQUENCE OF										A.C.V.D			
(b)										?			
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
ACUTE PYELOCYSTITIS													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
O								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
				HOUR A.M. P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
John F. Schaefer M.D.				JOHN F. SCHAEFER M.D.				22b DATE SIGNED 5.9.69					
ADDRESS (Street, city, town, or county)													
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c. NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
burial				5/12/69		Mt. Auburn Cemetery				Baltimore, Md. 21230			
24 FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REG STRAR		25b REG STRAR'S SIGNATURE			
Lewis T. Gwynn						4517 Park Heights Ave.		MAY 13 1969		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-66

06528

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06526

1. DECEASED-NAME (Type or print) <u>John B Heath</u>			2a. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>69</u>			2b. HOUR <u>6:30 AM</u>	
3 SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>April 25, 1881</u>		6. AGE (In years last birthday) <u>88</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md	
10. CITY OR TOWN OF DEATH <u>Cockeysville Md</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Masonic Homes</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Stone Machinist</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Stone Machinist</u>	
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Balto</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>4411 Whit Ave</u>		14. FATHER'S NAME First <u>George W</u> Middle <u>Heath</u> Last <u>Cediala</u>		15. MOTHER'S MA DEN NAME First <u>Emma</u> Middle <u>Cediala</u> Last <u>Cediala</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>212-08-0865</u>		17. INFORMANT <u>Masonic Home Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purmonary Thrombosis</u>							<u>7 days</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio-Sclerotic Vas. Heart Disease</u>							<u>10 yrs.</u>
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. ex. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 7</u> , 19 <u>69</u> , to <u>May 9</u> , 19 <u>69</u> , that (I) <u>was</u> last saw the deceased alive on <u>May 9</u> , 19 <u>69</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) <u>not</u> view the body after death							
22b. SIGNATURE <u>Carl F. Benson MD</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>May 10, 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>Carl F. Benson MD</u>				22e. ADDRESS <u>5111 York Rd Balto. Md 21212</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 13, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		23d. LOCATION (City or Town) (County) (State) <u>Bal</u>	
24. FUNERAL DIRECTOR <u>Wm Cook Burkhartson</u>				ADDRESS <u>1050 York Rd Towson Rd</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 12 1969</u>	
				25b. REGISTRAR'S SIGNATURE <u>Wm Cook Burkhartson</u>			

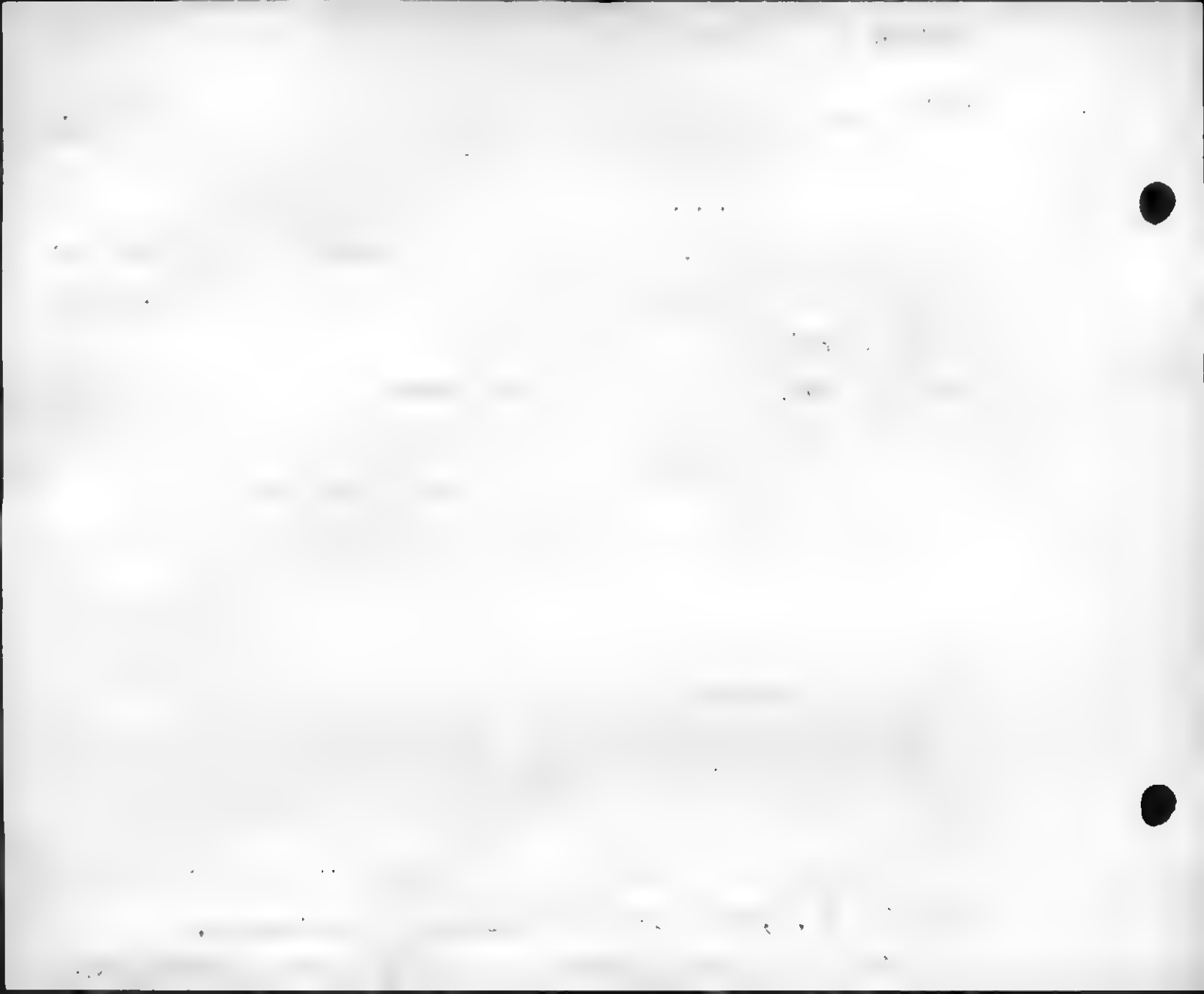
21504



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

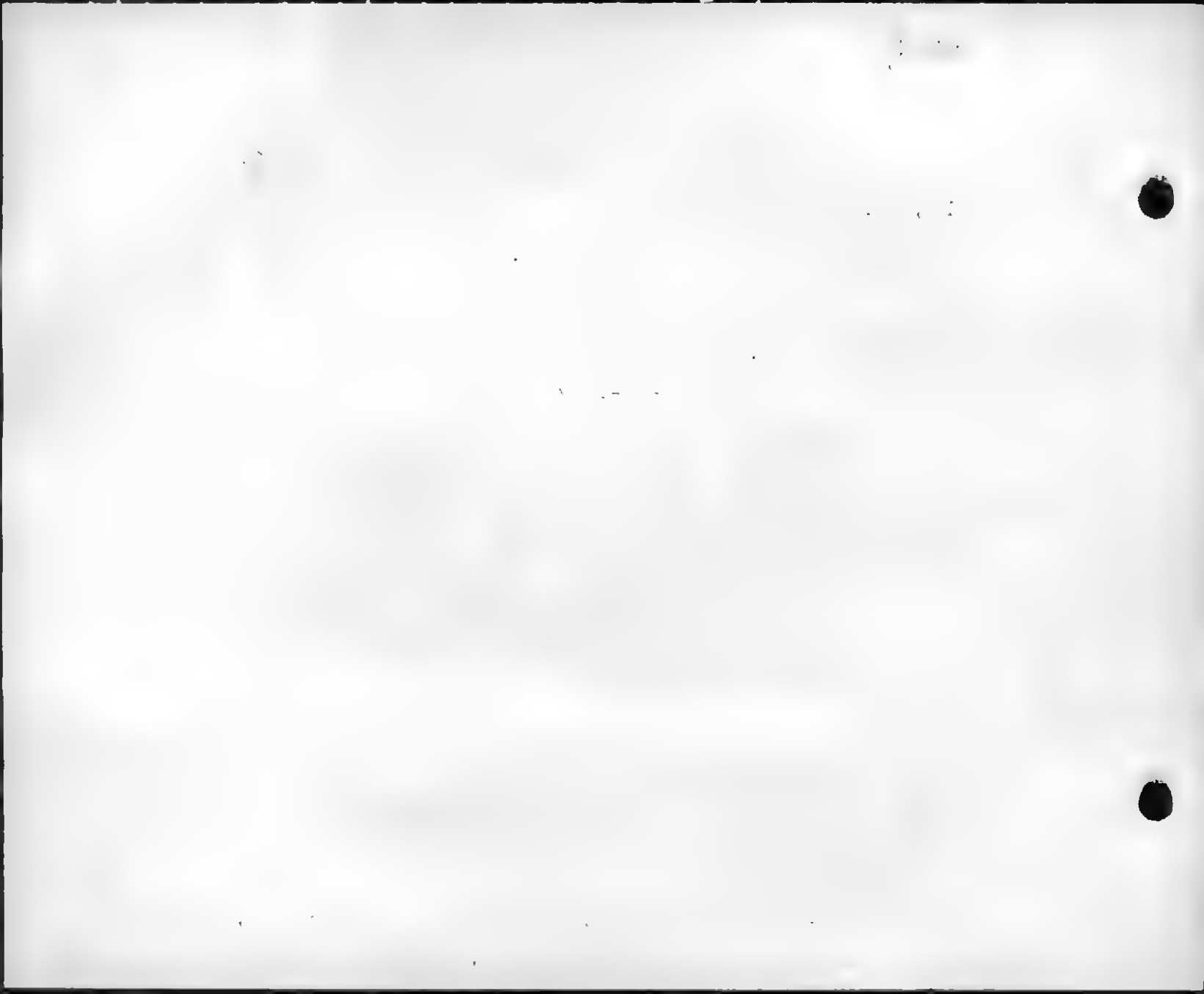
<div style="display: flex; justify-content: space-between;"> 06529 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06527 </div>											
1. DECEASED NAME (Type or print) Lakie Victoria Held						2a. DATE OF DEATH Month May Day 31 Year 69			2b. HOUR 7.50 PM		
3 SEX Female		4 RACE White		5. DATE OF BIRTH 4-21-14			6 AGE (In years last birthday) 55 YRS		IF UNDER 1 YEAR MONTHS 55 DAYS 55 HOURS 55 MIN		IF UNDER 24 HRS HOURS 55 MIN
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md		
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during usual life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER 1729 Kurtz Ave., 21093		
14 FATHER'S NAME First Middle Last Charles Beard				15 MOTHER'S MAIDEN NAME First Middle Last ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. None		17 INFORMANT Family records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal carcinomatosis (bronchogenic carcinoma) 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary thrombo-embolism, right lung. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (A) (this hospital) attended the deceased from 4/5/1969 to 5/31/1969 , that (X) (we) lost the deceased alive on 5/31/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Christina Feliciano, M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED June 1, 1969	
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D.						22e. ADDRESS 7620 York Rd., Towson Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 3, 1969		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland						25a. REC'D BY REGISTRAR JUN 4 1969		25b. REGISTRAR'S SIGNATURE John Burns' Sons			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
06530		06528							
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Joseph Edmund Henneberger						Month 5 Day 15 Year 69		2:07	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		6-28-02		66 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Balto, Md.		USA				Baltimore		Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INST. T.J.T. ON (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown			Balto Co. Gen			Banker		Banking	
13a. U.S.A. RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md			Baltimore			Baltimore			
4. FATHER'S NAME First Middle Last			15. MOTHER'S NAME First Middle Last						
Joseph R. Henneberger			Elsie Fredericks			XXXXXXXXXX			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
NO			216-14-1397			Katherine Lips Henneberger-Durley Lane			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))									APPROX. MATE. INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u>									3 yrs.
1621 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
Sept. '66		Ca. of Lung							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		19 P.M.							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10-29-1968, to 5-14-1969, that (I) (we) last saw the deceased alive on 4-22-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
Cardinal J. J. M. J.				5-16-69					
22d. PHYSICIAN'S NAME				22e. ADDRESS					
W. B. ALLEN, M.D.				68 Eager St. Bel Air, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)			
Burial		5-17-69		Druid Ridge Cemetery		Baltimore, Maryland		23e. SIGNATURE	
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE					
Armocost Funeral Chapel-4600 Liberty Hts.		MAY 20 1969		Charles Judge					

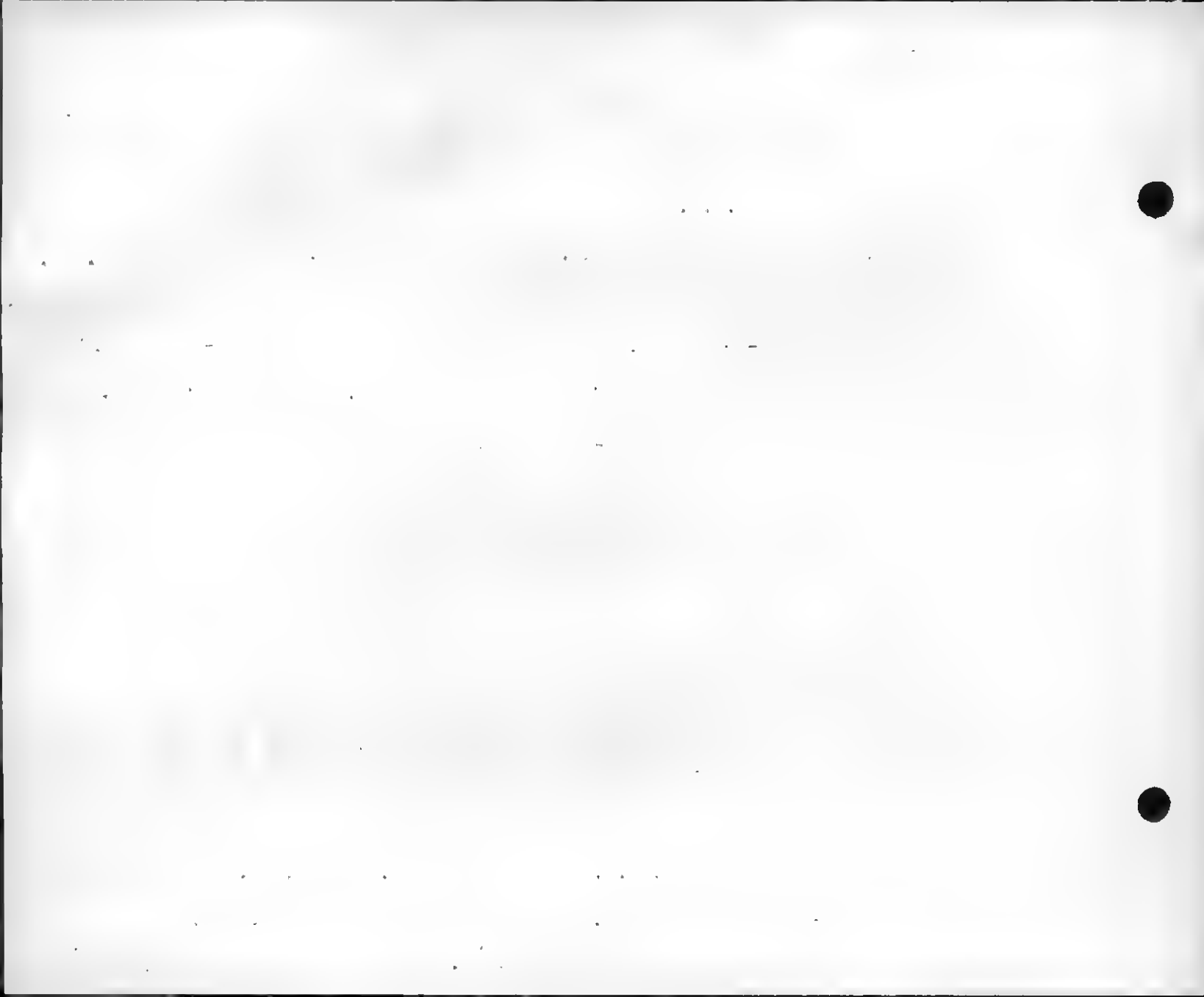


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VR A13 100
45M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06531					06529				
1 DECEASED-NAME (Type or print)					2a DATE OF DEATH		2b HOUR		
First Middle Last ELMER BRYAN HESS					Month Day Year MAY 23, 1969		9:00 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
MALE		WHITE		6/1/1900		68 YRS		IF UNDER 24 HRS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10a KIND OF BUSINESS OR INDUSTRY	
MARYLAND		U.S.A.				BALTIMORE		Equip. Co.	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
FORT HOWARD			VETERANS ADMIN. HOSPITAL			ENGINEER			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b CITY OR TOWN		13c INSIDE CITY, J.M.T.S.P. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET AND NUMBER		
MARYLAND			PASADENA				ROCKVIEW BEACH, BERTHA RD.		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
WILLIAM - - HESS			EMMA - - JOHNSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17. INFORMANT Address				
YES WWII			215 03 1221		CLINICAL RECORDS, VAH, FT. HOWARD, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA, TERMINAL									DAYS
4123 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE									YEARS
DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE									MONTHS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (he) (this hospital) attended the deceased from MAR 8, 1969 to MAY 23, 1969 , that (he) (we) last saw the deceased alive on MAY 23, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (do not) view the body after death.									
22b SIGNATURE <i>Pushpendra Senan</i> DEPT. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c DATE SIGNED 5/24/69			
22d PHYSICIAN'S NAME (Type) PUSHPENDRA SENAN, M.D.						22e ADDRESS VAH, FT. HOWARD, MD.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		5-27-1969		BALTO. NATIONAL CEMETERY		BALTO., MD.			
24 FUNERAL DIRECTOR GEORGE GONCE FUNERAL HOME, RIVIERA BEACH, MD.				25a REC'D BY REGISTRAR MAY 29 1969		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

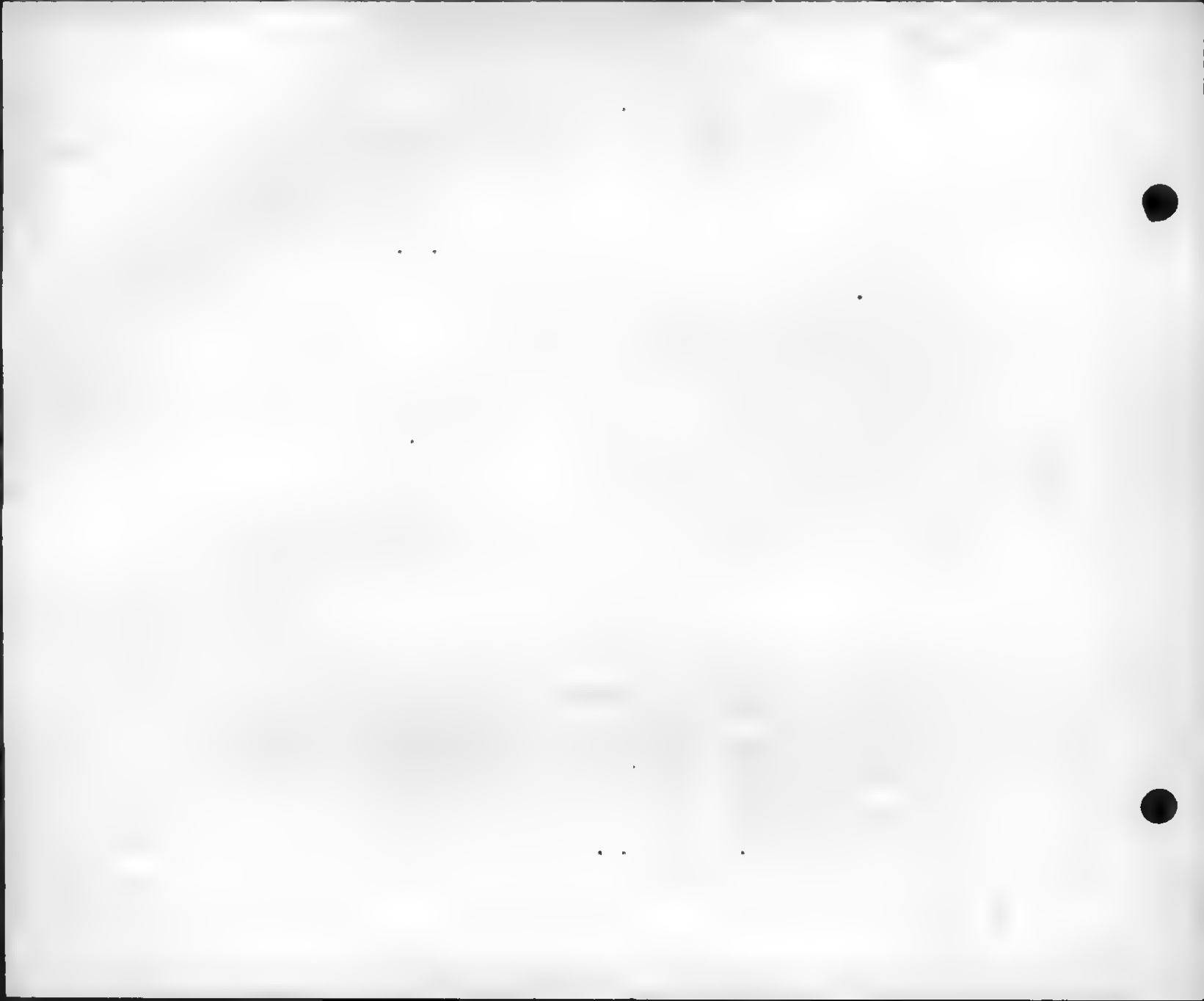
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 7 hours after death.

06532

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06530

1. DECEASED-NAME (Type or Print) HARRY Middle E. Last Hess		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 5 Day 10 Year 1969		2b. HOUR 10:30 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9/1/23	6. AGE (In years last birthday) 45 YRS	7. IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) PA.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County Md
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 818 Old North Pt. Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First BENJAMIN F. Middle H. Last HESS		15. MOTHER'S MAIDEN NAME First SORREST Middle S. Last SORREST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. MM-11		17. INFORMANT B.F. HESS ADDRESS ABOVE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty alteration of liver. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 118				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Werner U. Spitz M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED May 11, 1969
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5/14/69	23c. NAME OF CEMETERY OR CREMATORY OAK LAWN	23d. LOCATION (City or Town) BALTO. MD. (County) (State)	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE		25a. REC'D BY REGISTRAR MAY 15 1969 25b. REGISTRAR'S SIGNATURE

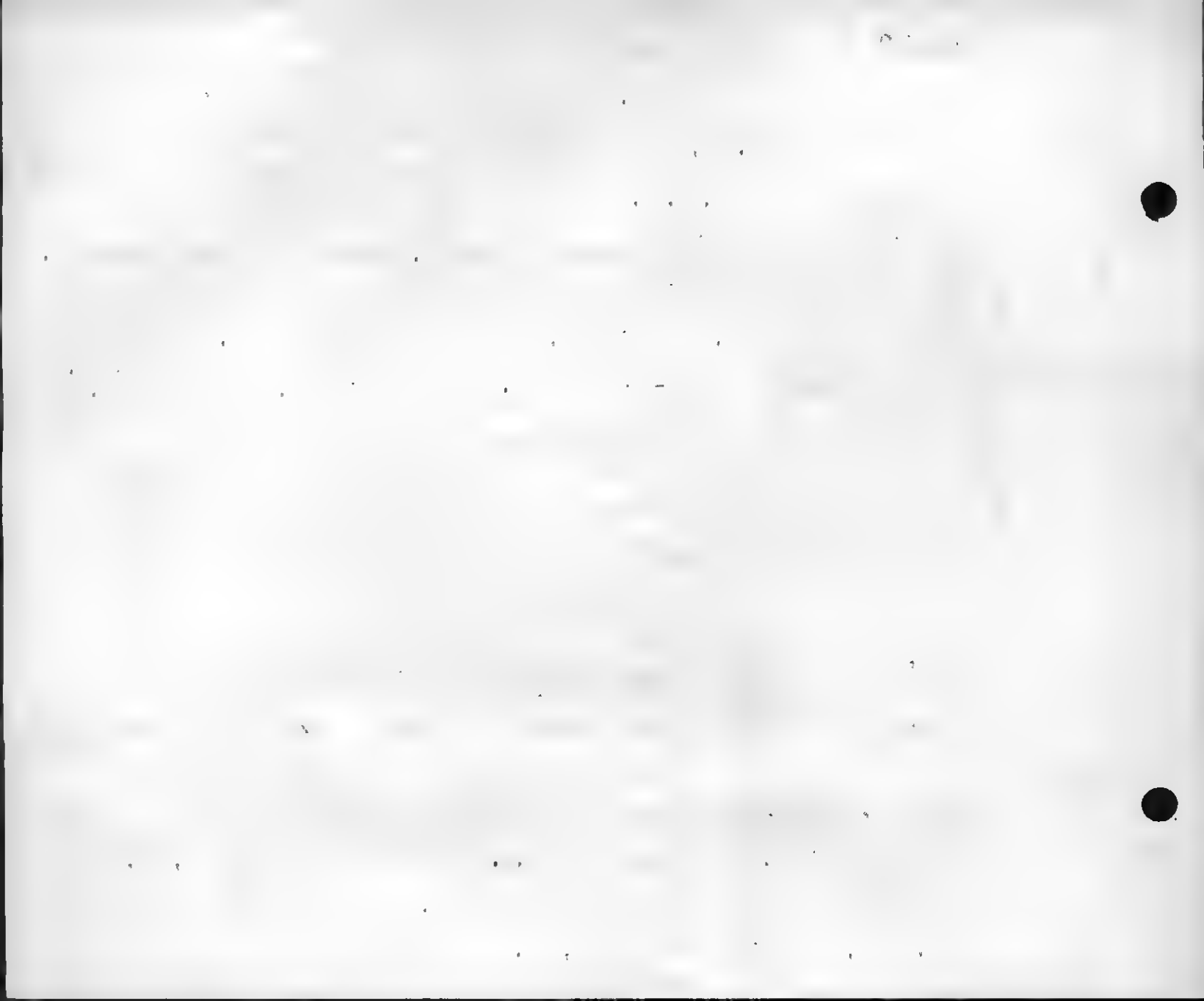


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PD-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print)			First Kenneth		Middle W.		Last Hewitt		2a DATE KNOWN OF DEATH Month Day Year May 4 1969			
3 SEX Male		4 RACE White		5. DATE OF BIRTH Dec. 13, 1948		6 AGE (in years last birthday) 20 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore			
10 CITY OR TOWN OF DEATH Back River			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Millers Island-Bay Shore Pk.						12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter - Coastal		12b KIND OF BUSINESS OR INDUSTRY Trailer Co.	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 7905 Trappe Road		
14. FATHER'S NAME First Middle Last Ross D. Hewitt Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Hilda M. Zeller									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b SOCIAL SECURITY NO. (When given, state or dates of service) Vietnam 252-82-2463			17 INFORMANT (Father) Mr. Ross D. Hewitt Sr.			ADDRESS Dundalk, Md. 7905 Trappe Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF 9100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year 7:00 A.M. May 19 1969			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Swimming & Stopped into Hole						
21d INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Ches. Bay-Back River			21f LOCATION (Street or R.F.D. No. City or Town County State) Millers Island-Bay Shore Pk - Dundalk - Md - Baltimore						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Melvin B. Davis			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED 5/5/69 6800 Morningside Road ADDRESS (Street, city, town, or county) Dundalk, Md. 21222			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 5/8/69			23c NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.			23d LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						25a REC'D BY REGISTRAR MAY 8 1969			25b REGISTRAR'S SIGNATURE John J. Duda			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

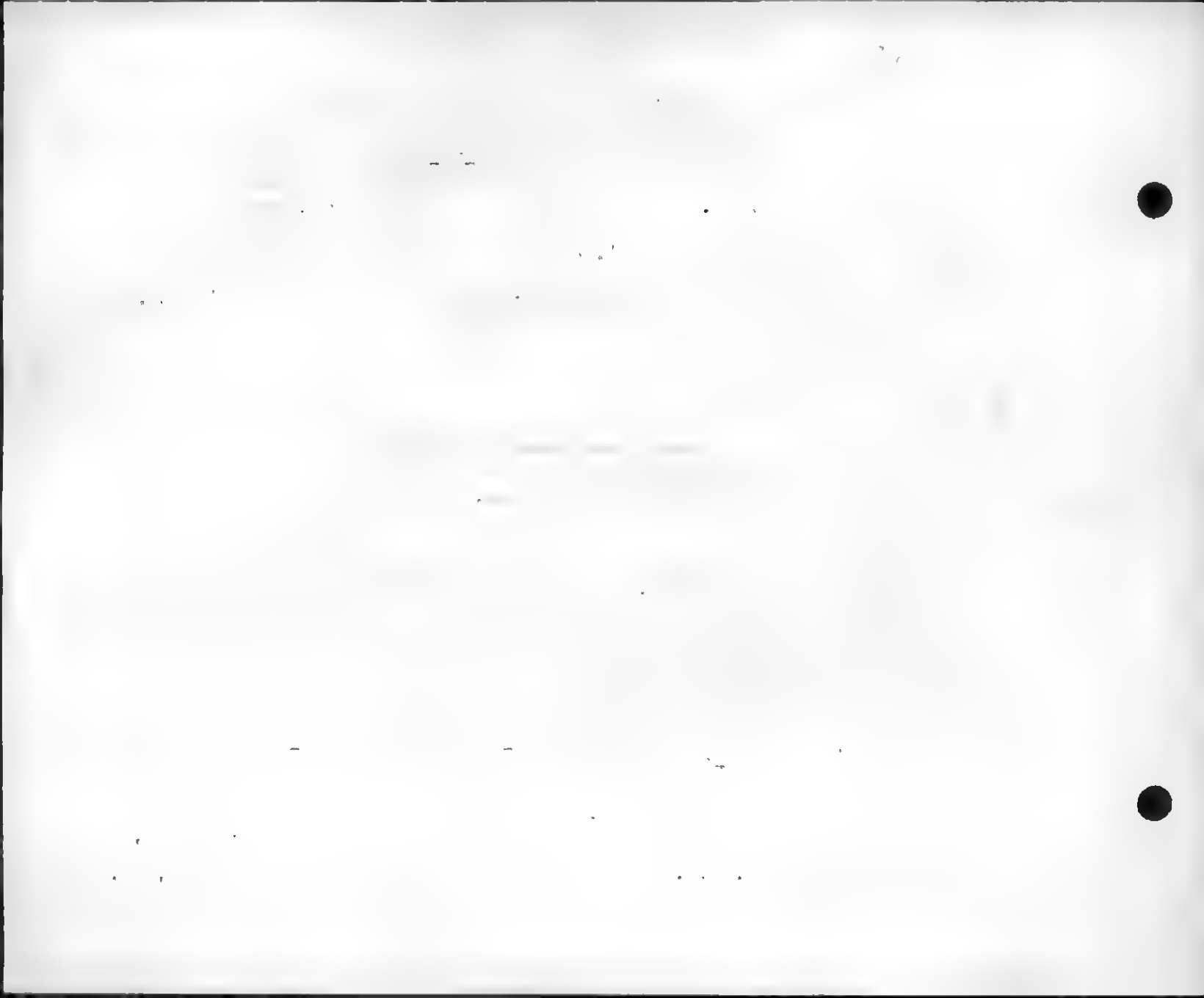
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06534

CERTIFICATE OF DEATH

06532

1. DECEASED-NAME (Type or print) First Middle Last Roland Edwin Hickey			2a. DATE OF DEATH Month Day Year May 5 1969		2b. HOUR P 3:45 M
3. SEX Male	4. RACE white	5. DATE OF BIRTH 9-18-26		6. AGE (In years last birthday) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M N
7a. BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Western Electric	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 625 Dunkirk Rd.	
14. FATHER'S NAME First Middle Last Edward J. Hickey		15. MOTHER'S MAIDEN NAME First Middle Last Pauline Ray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO 1-11-2		17. INFORMANT Address Mrs. Pauline Nicholson, Ashville, Ohio	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized purulent peritonitis MICROBIAL TOXICOINFECTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary embolism, bilateral DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Generalized peritonitis, total obstruction of bronchi by mucous; Questionable pancreatitis chronic pancreatitis.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 4/28/69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED R/O lesion in region of pancreas		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work	21b. TIME OF INJURY Hour A.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (this hospital) attended the deceased from 4-11 , 19 69 , to 5-5 , 19 69 , that (I) (we) last saw the deceased alive on 5-5 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE Samuel Lee, M.D.		DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED May 6, 1969	
22d. PHYSICIAN'S NAME (Type) Samuel Lee, M.D.		22e. ADDRESS 7620 York Road Baltimore, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May. 6, 1969	23c. NAME OF CEMETERY OR CREMATORY Harrison Township Cemetery		23d. LOCATION (City or Town) (County) (State) Piqua, Co. Ohio	
24. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home 4210 Belair Road,		25a. REC'D BY REGISTRAR MAY 7 1969	25b. REGISTRAR'S SIGNATURE William J. Judge		
For Bastian Funeral Home, Ashville, Ohio					



06535

CERTIFICATE OF DEATH

06533

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Itavere de Grace</u>	
c. LENGTH OF STAY IN TB <u>5 wks</u>		d. STREET ADDRESS <u>413 S. Stokes St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Octavius</u> Middle <u>Hicks</u> Last <u>Hicks</u>		4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1969</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-03</u>
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>24</u> Hours <u>19</u> Min <u>69</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE FAMILY</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Peterburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Arthur Hicks</u>		14. MOTHER'S M.A.D.N. NAME <u>Florence Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>224-01-9923</u>	
17. INFORMANT Address <u>Mr. Wardell V. Stansbury, Harvi de Grace, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: <u>4124</u> IMMEDIATE CAUSE (a) <u>MASSIVE CEREBRAL VASCULAR</u> DUE TO <u>ACCIDENT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: DUE TO (b) <u>ACCIDENT</u> (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>69</u> , to <u>5/14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/24</u> , 19 <u>69</u> , and that death occurred at <u>2:30</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>5/26/69</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Samuels, M.D.</u>		22d. ADDRESS <u>5800 Edmonson Ave. N.W. - Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-29-69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Balducci Mortuary</u> ADDRESS <u>556 Reisterstown Rd. Harvi de Grace, Md.</u>		25a. RECD BY REGISTRAR <u>JUN 2 1969</u>	
		25b. REGISTRAR'S SIGNATURE <u>Thomas Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A13 45M 1969

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06536

CERTIFICATE OF DEATH

06534

1 DECEASED NAME (Type or print) First John Middle Reid Last Hild			2a DATE OF DEATH Month May Day 7, 1969 Year 1969		2b HOUR 7:45 M
3 SEX male	4 RACE white	5 DATE OF BIRTH May 15, 1907		6 AGE (in years last birthday) 61 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS M N
7a BIRTHPLACE (State or foreign country) N. C.	7b CITIZEN OF WHAT COUNTRY? U. S.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore		10 CITY OR TOWN OF DEATH Catonville
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) engineer	12b KIND OF BUSINESS OR INDUSTRY Balto. Co.		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.	13b COUNTY Balto.	13c CITY OR TOWN Gwynn Oak	13d INS DE CITY, JAN 15? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 3220 North Holling Rd.	
14 FATHER'S NAME First Middle Last Elmer K. Hild		15 MOTHER'S M A DEN NAME First Middle Last Nettie Tate			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b SOCIAL SECURITY NO. 218-32-2320		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Choke while eating</u> DUE TO, OR AS A CONSEQUENCE OF <u>Heart</u> (b) <u>Time - 2 m approx</u> DUE TO, OR AS A CONSEQUENCE OF <u>Heart</u> (c) <u>Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 19, 1969, to May 7, 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (do not) view the body after death.					
22b SIGNATURE Rafael H. Marin, M.D.			22c. DATE SIGNED 5-7-69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE May 10, 69	23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d LOCATION (City or Town) (County) (State) Woodlawn Maryland	
24 FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown		25a. REC'D BY REGISTRAR DATE MAY 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

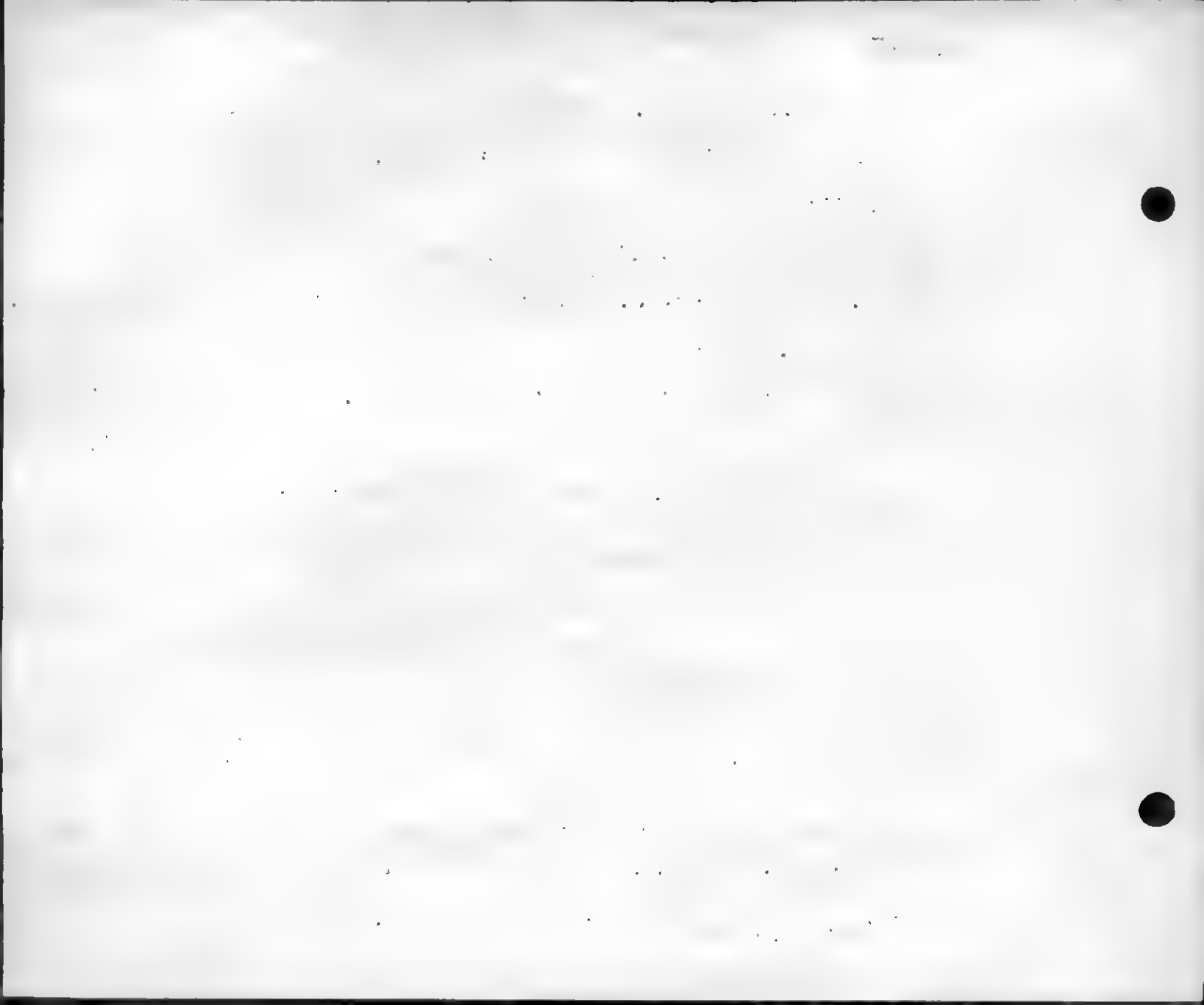


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VR 150
30M REV 1-68

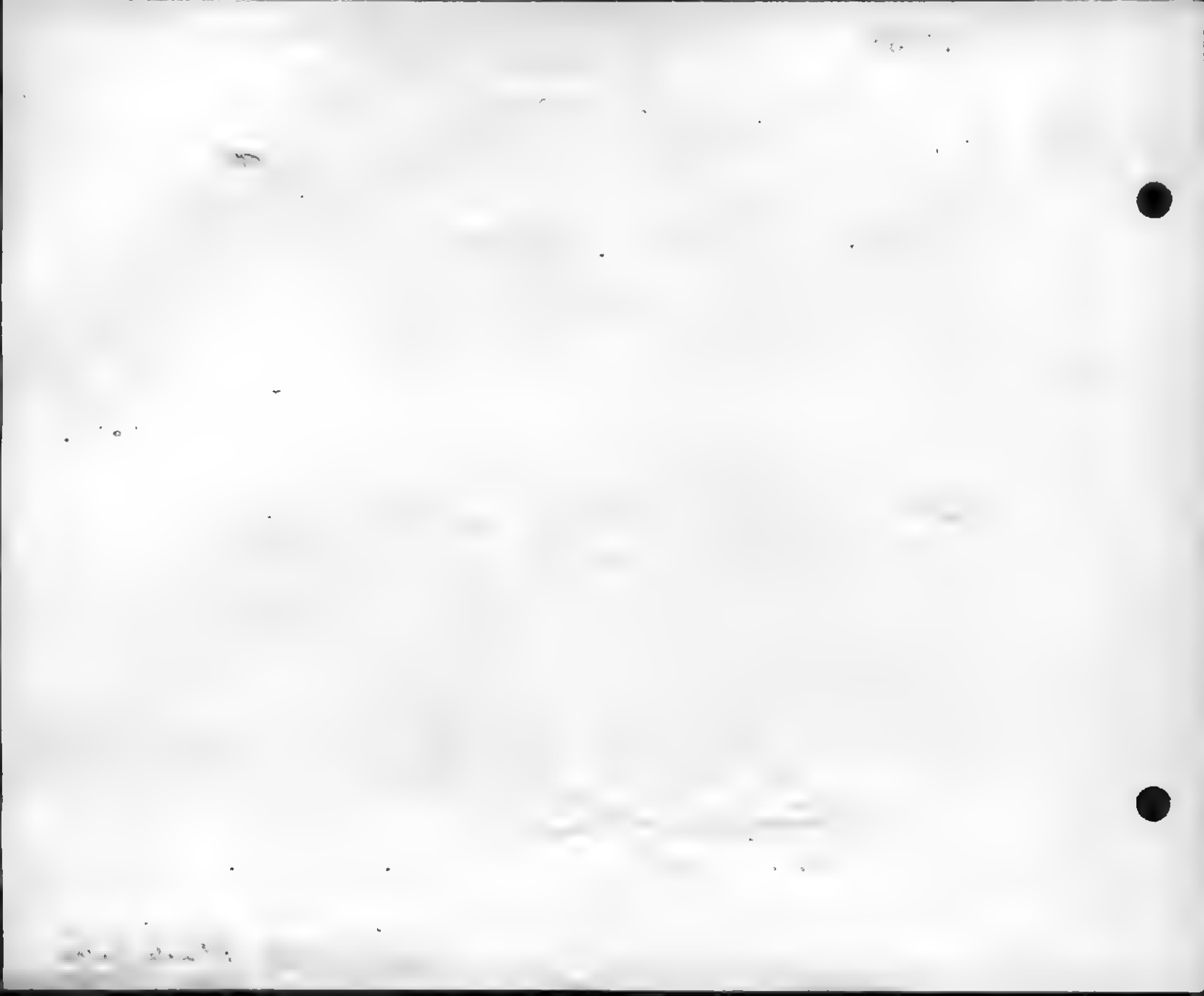
06537										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06535																																							
1 DECEASED NAME (Type or print) First Middle Last										2a DATE OF DEATH Month Day Year										2b HOUR M																																							
3 SEX female										4 RACE white										5 DATE OF BIRTH August 4, 1888										6 AGE (in years last birthday) 80 YRS										7 UNDER 1 YEAR MONTHS DAYS										7 UNDER 24 HRS HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Catonsville										7b. CITIZEN OF WHAT COUNTRY? USA										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.																													
10. CITY OR TOWN OF DEATH Catonsville										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) home										12b KIND OF BUSINESS OR INDUSTRY home																													
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.										13b. COUNTY Balto.										13c CITY OR TOWN Catonsville										13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 1916 Old Frederick Rd.																			
14. FATHER'S NAME First Middle Last James M. Hoffman										15 MOTHER'S MAIDEN NAME First Middle Last Katherine Kaiser																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no										16b SOCIAL SECURITY NO. none										17 INFORMANT Mrs Cecelia G. Hoffman										Address 1916 Old Frederick Rd.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo.																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) Asevd with cerebral ischemia										10 yes																																							
										DUE TO, OR AS A CONSEQUENCE OF (c)																																																	
										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 8 March, 1969, to 10 May 1969, that (I) (we) last saw the deceased alive on 10 May 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE James E. Rowe M.D.										22c. DATE SIGNED 5/12/69																																							
22d. PHYSICIAN'S NAME (Type) James E. Rowe, M.D.										22e. ADDRESS 5550 Baltimore National Pike 21228																																																	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial										23b DATE May 13, 1969										23c NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore, Maryland										23d LOCATION (City or Town) (County) (State)																													
24. FUNERAL DIRECTOR Sterling Funeral Estate										ADDRESS 736 Edmondson Ave. Catonsville, Md. 21228										25a RECD BY REGISTRAR MAY 15 1969										25b REGISTRAR'S SIGNATURE																													



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ORLANDO			H. HOWARD			MAY Month 20 Day 69 Year			10:30
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years lost to life)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		NEGRO		Oct 25, 1902		66 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Balto. Co., Md		U.S.A.				BALTIMORE		Md	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
BALTIMORE			GR. BALTO. MED. CENTER			chauffeur			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.			Cockeysville			Cuba Road			
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Joseph S. Howard			Martha E. Diggs						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.			17 INFORMANT Address			
No.			215-32-2688			Mrs. Eleanor A. Howard			Cuba Road
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) IRREVERSIBLE CARDIOGENIC SHOCK									4 1/2 HRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) CARDIAC ARREST									
(c) DUE TO, OR AS A CONSEQUENCE OF INTRA ABDOMINAL PATHOLOGY OF UNKNOWN ETIOLOGY									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		P.M. 19							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (Type)						22e ADDRESS		5-20-69	
DR. E. LARRANAGA						6701 N. CHARLES ST. BALTO. MD 21204			
23a BURIAL, CREMATION, REMOVA (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		5-24-69		Gough Meth. Ch. Cem.		Cockeysville, Md.			
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE			
MORTON & DYETT F.H. 1701 Laurens St.				DATE MAY 21 1969		J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed & filed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06539

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06537

CERTIFICATE OF DEATH

1. NAME OF DECEASED

(Type or Print)

ROSE M. HUNTER

2. DATE AND HOUR OF DEATH

MAY 27, 1969 5-A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

LITTLE SISTERS OF THE POOR
601 MAIDEN CHOICE LANE
BALTIMORE, MD. 21228

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE M.D. 21205

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

725 N. Port St.

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

7-12-1883

9. AGE (In years last birthday)

85

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore
MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Svrjcek

14. MOTHER'S MAIDEN NAME

BARBARA HAYLECK

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Sister George Superior
601 Maiden Choice Lane, Balt. Md. 21228

ADDRESS

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

C. V. A.

(B)

DUE TO, OR AS A CONSEQUENCE OF

Arteriosclerosis

(C)

Senile

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION

22. I certify that (I) (this hospital) attended the deceased from

1968 to May 27, 1969

that (I) (we) last saw the deceased alive on

May 27, 1969

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Barney Bontemps

Attending Phys ☒

Med. Director ☐

Staff Phys ☐

23B. DATE SIGNED

5.28.69.

23C. PHYSICIAN'S NAME (Type)

DR. S. ANKUDAS M.D.

23D. ADDRESS

1101 MAIDEN CHOICE LANE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5/31/69

24C. NAME of CEMETERY or CREMATORY

Lorraine Park Cem.

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT

45M

JUN 6 1969

25B. NAME OF REGISTRAR

Charles J. J...

25C. FUNERAL DIRECTOR

3331 Brehms Lane
Schumerh...

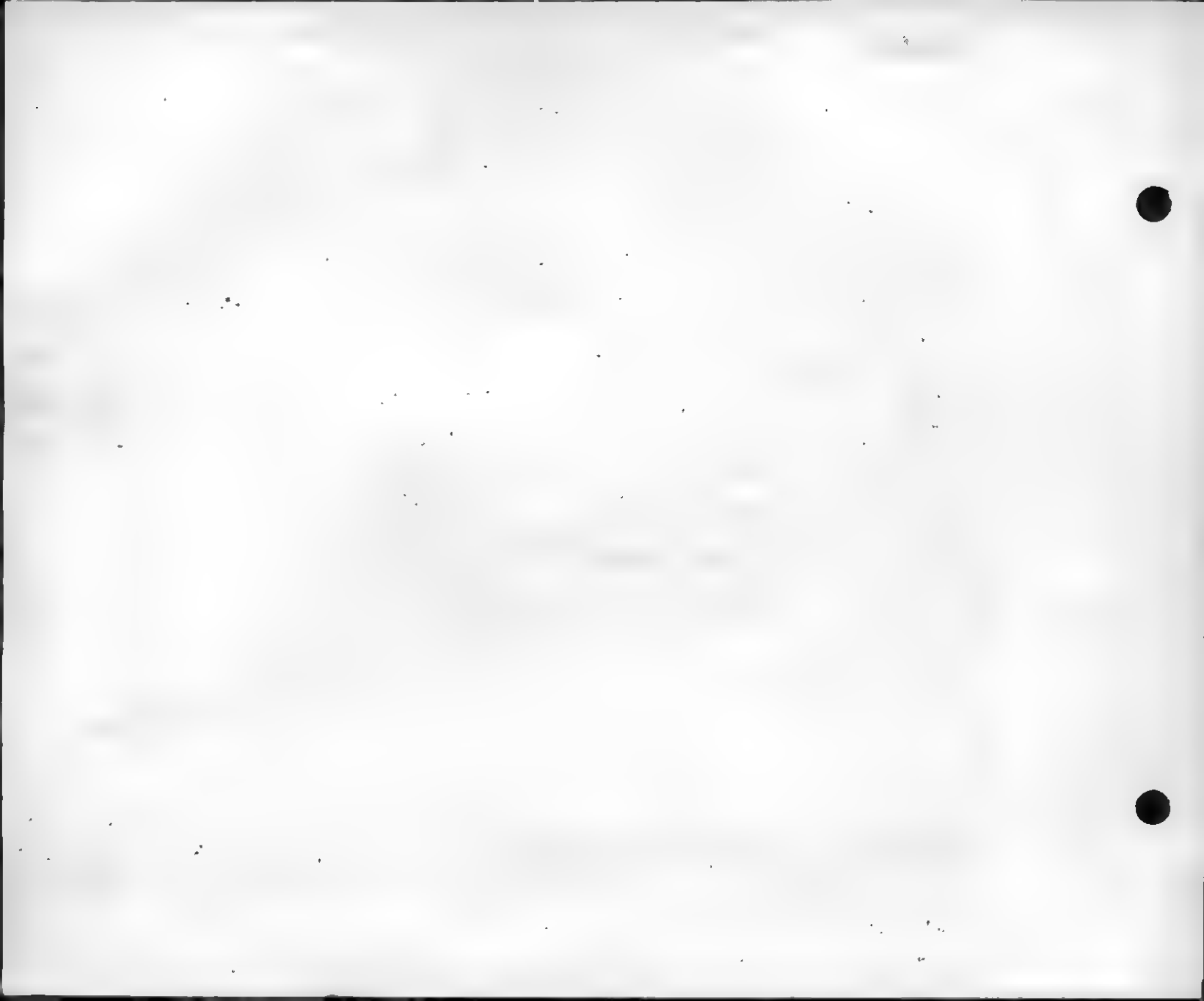


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) M
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> 06540 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06538 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div>																				
1. DECEASED-NAME (Type or print) Nora			First Huntley			Middle Huntley			Last Huntley			2a. DATE OF DEATH May Month 9 Day 1969 or			2b. HOUR 11 A M					
3 SEX Female			4 RACE Negro			5 DATE OF BIRTH 1-1-1897			6. AGE (In years last birthday) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS 			IF UNDER 24 HRS HOURS MIN 					
7a. BIRTHPLACE (State or foreign country) S. Carolina			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore County Md											
10 CITY OR TOWN OF DEATH Edgemere			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2401 Ruth Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic			12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Edgemere			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2401 Ruth Ave.								
14. FATHER'S NAME First Giles Middle - Last Huntley			15. MOTHER'S MAIDEN NAME First Hannah Middle Last ?																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address Lillie Covington 2401 Ruth Ave.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 15 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from Jan 15 , 19 60 , to May 7 , 19 69 , that (I) (we) last saw the deceased alive on May 7 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE John V. Conway M.D.			22c. DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22e. DATE SIGNED May 10 1969											
22d. PHYSICIAN'S NAME (Type) John V. Conway M.D.			22e. ADDRESS 914 D St, Balt, Md 21208																	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial-Transit			23b. DATE 5-14-69			23c. NAME OF CEMETERY OR CREMATORY Flintridge Cemetery			23d. LOCATION (City or Town) (County) (State) Pageland, S.C.											
24. FUNERAL DIRECTOR Marshall W. Jones, Jr.			ADDRESS 1735 Harford Ave.			25a. REC'D BY REGISTRAR DATE MAY 13 1969			25b. REGISTRAR'S SIGNATURE James Jones											



1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

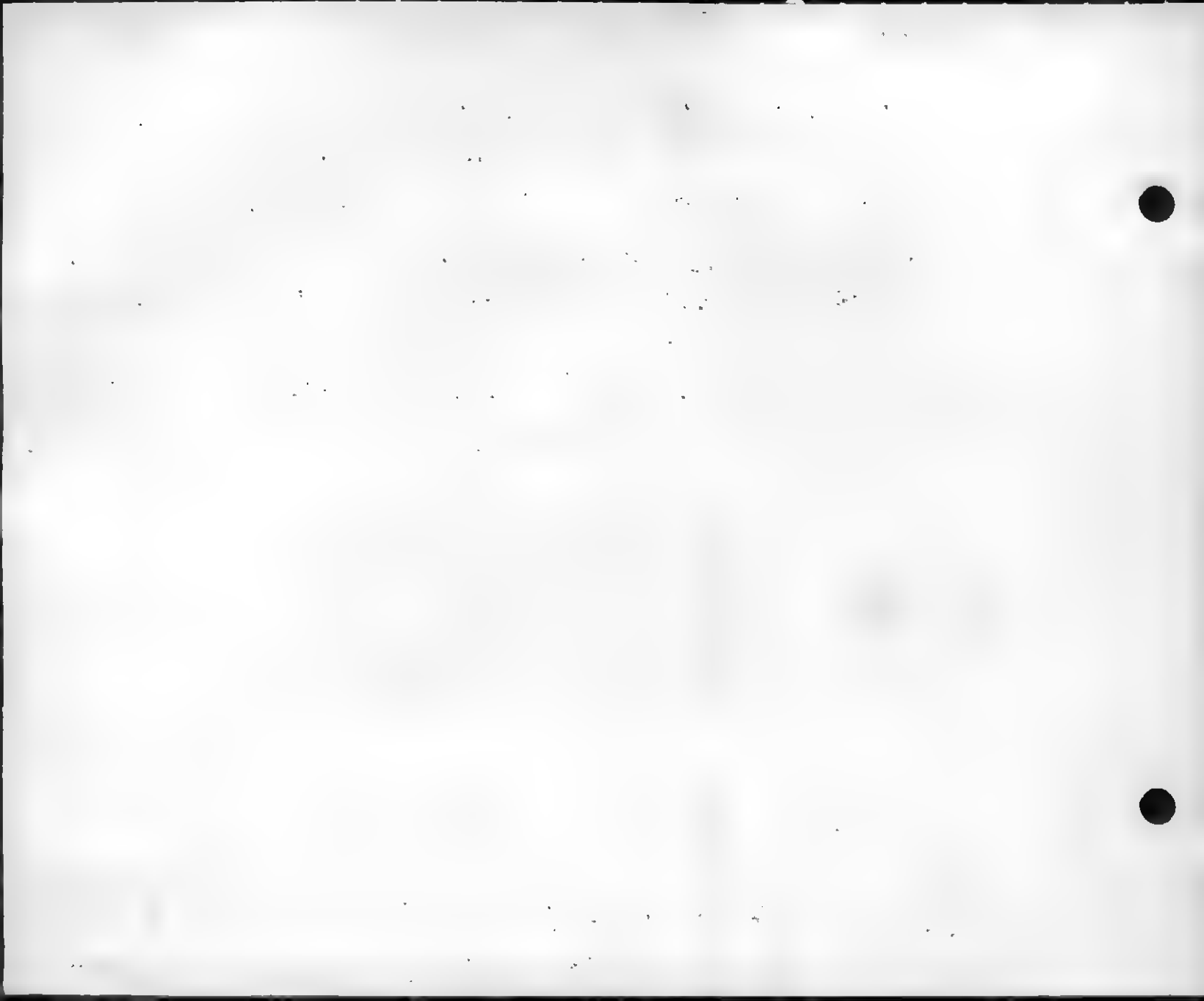
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06541

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06539

1. DECEASED-NAME (Type or print) WALTER A. JAGELSKI			2a. DATE OF DEATH Month MAY Day 18 Year 1969			2b. HOUR M				
3. SEX M		4. RACE W		5. DATE OF BIRTH JULY 9, 1908		6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MO.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.		Md.		
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 133 HAMPSHIRE RD		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) AUTO		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MO		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 133 HAMPSHIRE RD.		
14. FATHER'S NAME First Middle Last BRUNO JAGELSKI			15. MOTHER'S MAIDEN NAME First Middle Last VICTORIA ZAMIESKI							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) UNK		16b. SOCIAL SECURITY NO 213-10-4833		17. INFORMANT EVA JAGELSKI		Address ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 110 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John Hyatt				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/19/69				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 11 E. Chase Street						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/21/69		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		23d. LOCATION (City or Town) (County) (State) BALTO. MD.				
24. FUNERAL DIRECTOR J.G. CONNELLY SONS				ADDRESS 300 MALE		25a. REC'D BY REGISTRAR MAY 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
William Randolph		Jefferson						May 2, 1969		3:10 PM	
3. SEX	4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		7. UNDER YEAR MONTHS DAYS		
Male	Negro		1-10-1910				59 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md			
Maryland		USA				Baltimore					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY, Y, N, T, P?		13e. STREET AND NUMBER	
Maryland			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2211 N. Calvert St.		21202	
14. FATHER'S NAME First Middle Last				15. MOTHER'S M A D E N NAME First Middle Last							
Alexander Jefferson				Maggie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address							
yes		WW II		212-16-6660		Geraldine Thomas - 2119 Hollins St.					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis, Right											
4330 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Essential Hypertension											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Acute Renal Failure											
PART 2. OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a))											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 9, 1969, to May 2, 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 2, 1969, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE								22c. DATE SIGNED			
Gualberto Gokim, Jr. - M.D. DEGREE								May 2, 1969			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
Gualberto Gokim, Jr. M.D.				7620 York Road Baltimore, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		5-7-69		Baltimore National		Baltimore, Maryland					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Charles R. Law				802 Madison Ave.				MAY 6 1969			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOJR			
Robina Waurie Jenne						Month Day Year MAY 5 1969		8:30 PM			
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Female	White		12-29-99			69 YRS					
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH						
PA.	U.S.A.				Baltimore Md						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b K.IND OF BUSINESS OR INDUSTRY			
GARRISON, Md.			Foxleigh Nursing Home			Housewife		Crown Home			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
md			Baltimore		BALTO		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5429 Bradin Ave		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
David					Kirk	Jean M.					Ward
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT		Address				
No			None		264-22-9788		Mr. Arthur Jenne, 5429 Bradin Ave				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Illness</u> 1125 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from 10-15, 1967, to 5-5, 1969, that (I) (we) last saw the deceased alive on 5-4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Vicente M. Rurido						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 5-5-69			
22d PHYSICIAN'S NAME (Type) VICENTE M. RURIDO						22e ADDRESS 1637 Preston Rd. P.O. Box 100					
23a BURIAL, CREMATION, or other disposal			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)		
Burial			May 8, 1969		Pine Ridge Cemetery		Pikesville		Baltimore Md		
24 FUNERAL DIRECTOR Frank D. Newell						25a. REC'D BY REGISTRAR MAY 12 1969		25b REGISTRAR'S SIGNATURE Charles E. Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
45M

<div>06544</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06542</div>											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
RUTH ELIZABETH JOHNS						MAY Month 16 Day 69 Year			9:15 AM		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR		
FEMALE		WHITE		August 14, 1914			54 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
Balto., Md.		U.S.A.				BALTIMORE			At Home		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street and house no.)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			GR. BALTO. MED. CENTER			House Work					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. CITY OR TOWN			13c. INS. OF CITY, TOWNSHIP			13e. STREET AND NUMBER		
Md.			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4600 Valley View Ave. #06.		
14. FATHER'S NAME			15. MOTHER'S M. A. D. N. NAME								
First Middle Last			First Middle Last								
William B. Smith			Mary Cooper								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			None			Reuben D. Johns			4600 Valley View Ave. #06.		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CA M BREAST WITH WIDESPREAD METASTASES											
114X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						MAY 11 69 MAY 16 69					
22a. I certify that (I) (this hospital) attended the deceased from MAY 11 1969, to MAY 16 1969, that (I) (we) last saw the deceased alive on MAY 16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE									22c. DATE SIGNED		
M. I. Mansour									5-16-69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
MAHMOUD I. MANSOUR						6701N. CHARLES ST. BALTO. MD 21204					
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			5-20-69.			Oak Lawn Cemetery			7225 Eastern Blvd., Ba. Co., Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Charles S. Jiles						DATE MAY 21 1969			Charles Jiles		
901 S. Conkling St. Balto., 21224, Md.											



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

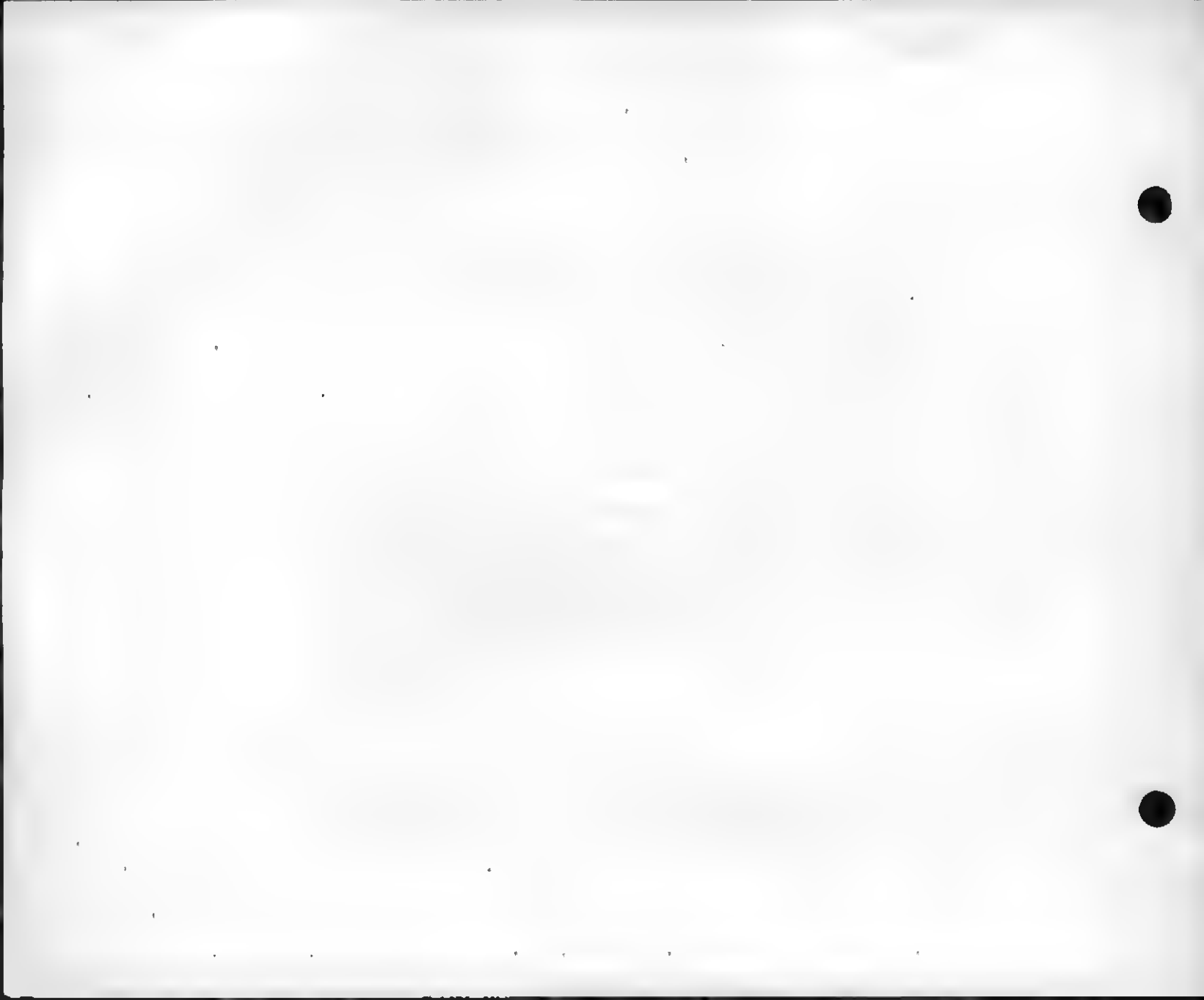
06545

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06543

1 DECEASED-NAME (Type or Print) First Eleanor Middle H. Last Johnson		2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF EST- DEATH MATED <input type="checkbox"/> May 28, 1969		2b HOUR 12 noon
3 SEX Female	4 RACE White	5 DATE OF BIRTH Sept. 10, 21	6 AGE (In years last birthday) 47 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Md
10 CITY OR TOWN OF DEATH Edgemere		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2512 Haddaway Road		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Baltimore	13c CITY OR TOWN Edgemere	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME First Middle Last Elmer H. Griffith		15 MOTHER'S MAIDEN NAME First Middle Last Edna F. Gough		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If give war or dates of service) 220-30-2195		17 INFORMANT (Husband) ADDRESS Edgemere, Md. LeRoy G. Johnson Sr. 2512 Haddaway Road,
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-I-DENSE</u> 4124 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>OK for burial. (3) Report new</u>				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town County State
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Melvin B. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/> 22b DATE SIGNED 5/29/69 6800 Mornington Rd. M. D. ADDRESS (Street, city, town, or county) Dundalk, Md. 21222		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 6/2/69	23c NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a REC'D BY REGISTRAR JUN 2 1969		25b REGISTRAR'S SIGNATURE Othello J. Judge

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page
5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

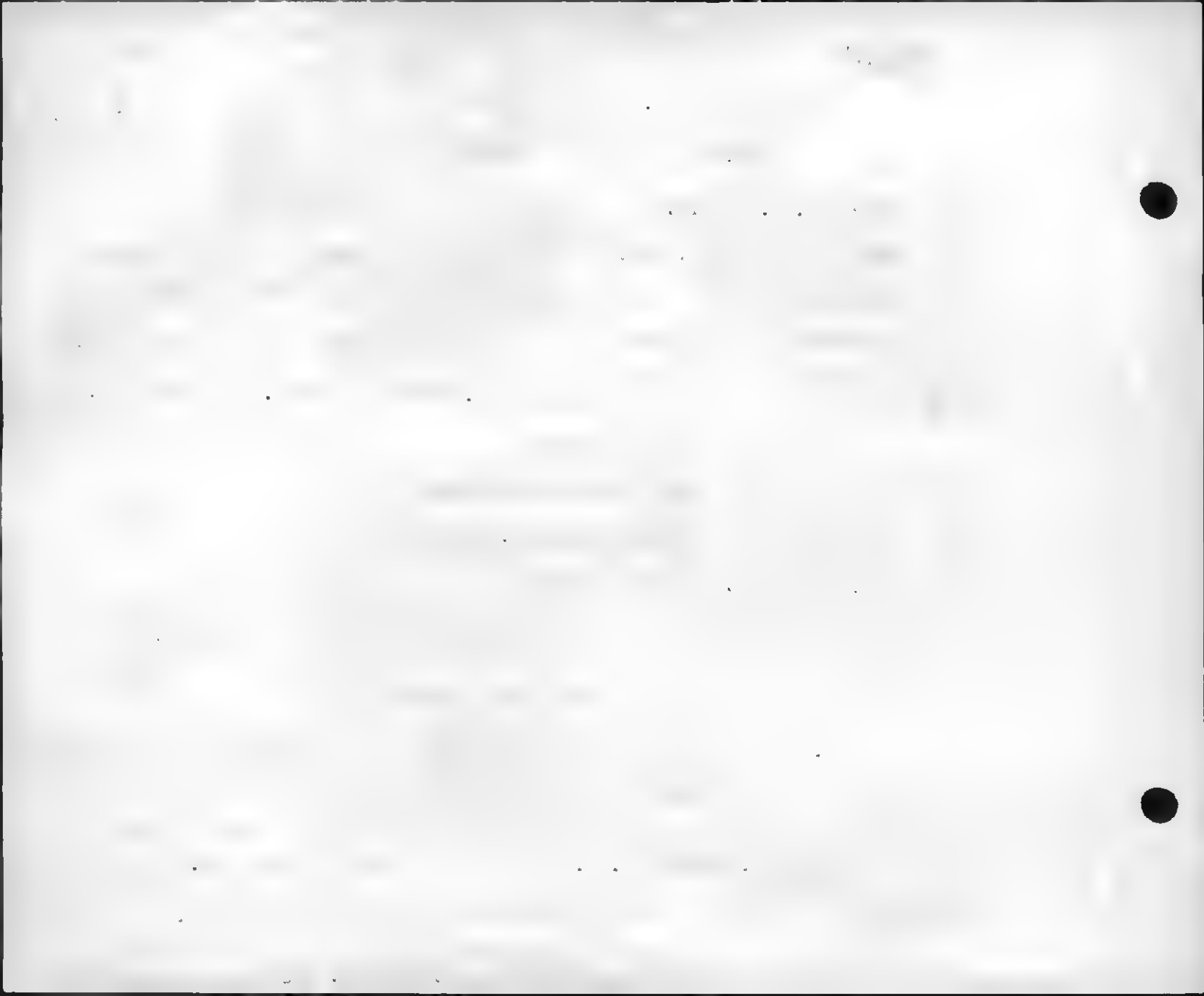
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06546

06544

1. DECEASED-NAME (Type or print) First Middle Last RANDOLPH B. JOHNSON			2a. DATE OF DEATH Month Day Year 5 13 69 2b. HOUR 5:20A M	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 12/10/08
7a. BIRTHPLACE (State or foreign country) PRINCE GEORGE CO. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VEH. ADM. HOSPITAL		9. COUNTY OF DEATH BALTIMORE
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LAUNDRY		12b. KIND OF BUSINESS OR INDUSTRY LAUNDRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last ASHTON JOHNSON		15. MOTHER'S MAIDEN NAME First Middle Last LOTTIE VERMILLION		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO 218 18 17 27		17. INFORMANT Address CLIN. RECORDS, VA HOSP. FT HOWARD, MD.
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS, GENERAL				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS. CARDIAC ISCHEMIA				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no autopsy				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State
22a. I certify that (1) (X) this hospital attended the deceased from 4/21/69 , 19__, to 5/13/69 , 19__, that (1) (we) last saw the deceased alive on 5/13/69 , 19__, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (d) (d) (d) view the body after death.				
22b. SIGNATURE <i>Erhard J. Bunyor M.D.</i>		22c. DATE SIGNED 5/13/69		
22d. PHYSICIAN'S NAME (Type) ERHARD J. BUNYOR, M. D.		22e. ADDRESS VAH FT HOWARD, MD.		
23a. BURIAL CREMATION, REBURY (Specify) BURIAL		23b. DATE 5/16/69		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY
23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.				
24. FUNERAL DIRECTOR <i>Ann Donovan</i>		25a. REC'D BY REGISTRAR MAY 16 1969		25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>
25c. ADDRESS DONOVAN FUNERAL HOME		25d. ADDRESS 3800 Roland Ave. Baltimore, Md. 21211		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

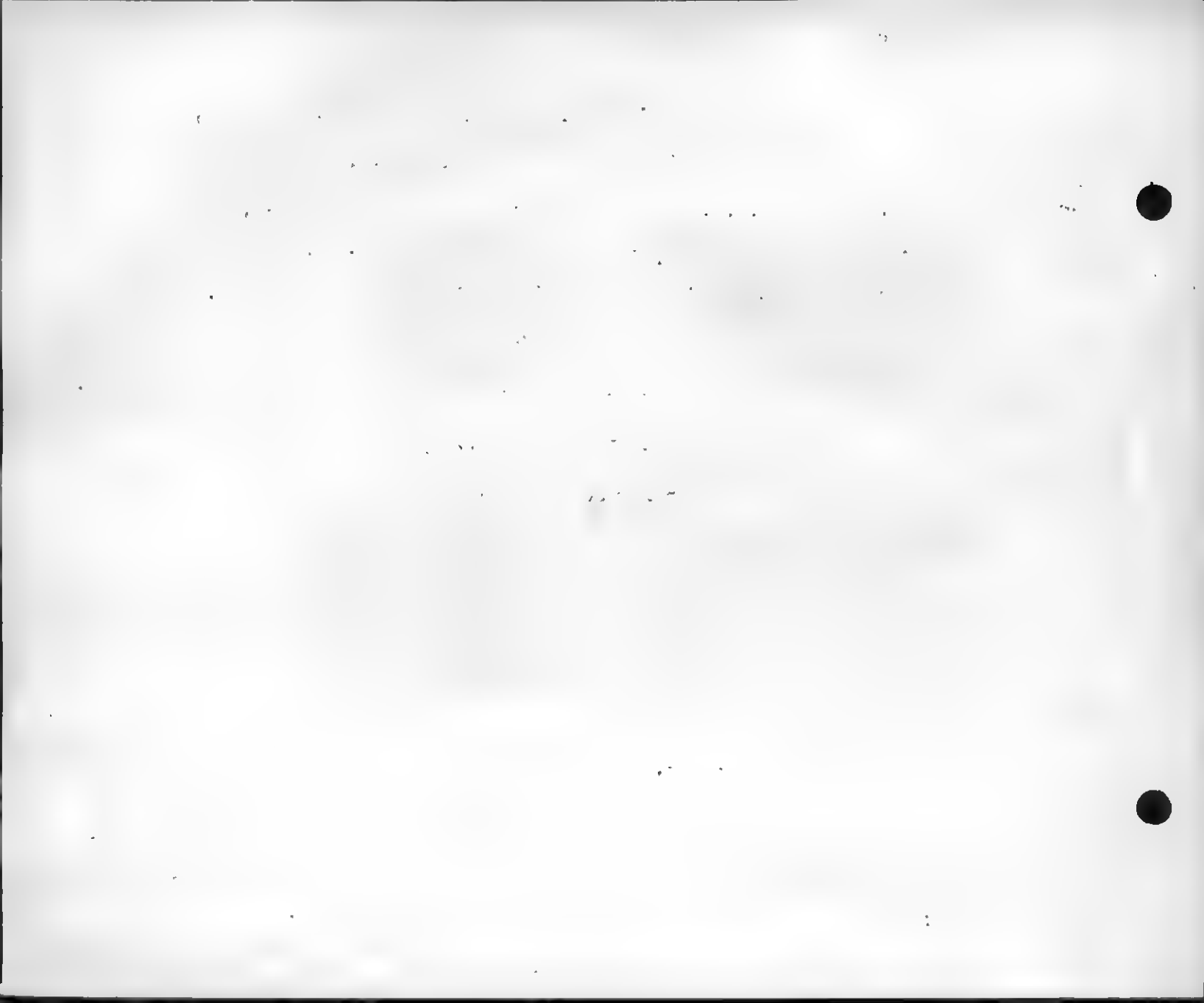
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH	
DAVID		LEE		JONES		Month 5 Day 26 Year 69		2b HOUR 12:20A M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		6/28/26		42 YRS.		IF UNDER 24 HRS. HOURS M N	
7a BIRTHPLACE (State or foreign)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY	
EASTON, MARYLAND		U.S.A.				BALTIMORE		ANTIQUE BUSINESS	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VET. ADM. HOSPITAL		CLERICAL					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND		QUEEN ANNE		CHESTER					
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last	
JEROME		JONES		PEARL		CROUCH			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, please give details of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
YES		WW II		093 20 86 93		CLIN. RECORDS, VA HOSP. FT HOWARD, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS WITH WIDESPREAD METASTASES									
150X DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21c. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 1/13/69, 19, to 5/26/69, 19, that (X) (we) last saw the deceased alive on 5/26/69, 19, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) not view the body after death.		22b SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 5/26/69	
22a PHYSICIAN'S NAME (Type)		GEORGE C. MC ELPATRICK, M. D.		22b ADDRESS		VAH FORT HOWARD, MARYLAND			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCAT ON (City or Town) (County) (State)			
BURIAL		MAY 29		STEVENSVILLE		STEVENSVILLE, MD.			
24 FUNERAL DIRECTOR		ALICE LANE FUNERAL HOME		REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Alyce R. Lane		CHURCH HILL, MARYLAND		JUN 3 1969		Alyce R. Lane			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>3</div> <div>1</div> <div>06548</div> <div> <div>MD</div> <div> <div>DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> <div>CERTIFICATE OF DEATH</div> <div>06546</div> </div>									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
MARY			ELIZABETH JONES			MAY Month 6, Day 1969 Year		1:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
FEMALE		NEGRO		SEPTEMBER 14, 1909		59 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				BALTIMORE			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON			ST. JOSEPH HOSPITAL			DAY WORKER			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARTLAND			HARTFORD		WHITE HALL		TROYER RD. #21161		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
UNK.			FLORENCE LEONARD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No, or unknown <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
			215-32-9364		Mr. James Pringle		Hereford, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Bilateral Bronchial Pneumonia</u>									
4124 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Cardiovascular Accident</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from April 8, 1969, to May 6, 1969, that (I) (we) last saw the deceased alive on May 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		Ines Cilliani, M.D.				DEGREE		22c. DATE SIGNED	
								May 6, 1969	
22d. PHYSICIAN'S NAME (Type)		Ines Cilliani, M.D.				22e. ADDRESS			
						7620 York Road Baltimore, Md. 21204			
23a. B. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		5-10-69		Mt. Joy A.M.E. Cem.		Hereford, Maryland			
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MORTON & DYETT F.H.		1701 Laurens Street				May 9 1969		[Signature]	



Body has been released by the deputy Medical Examiner, Dr. John F. Schaefer. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

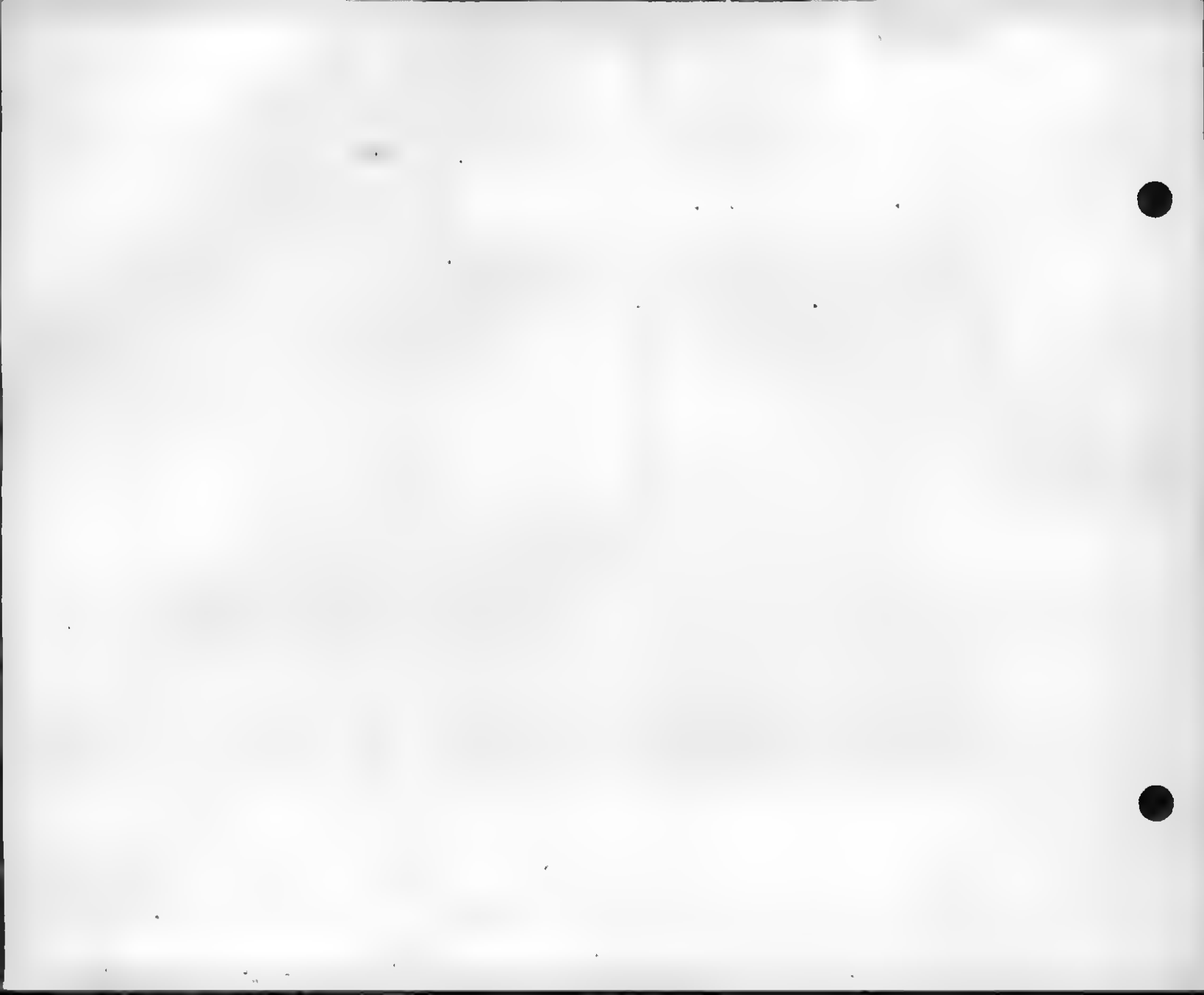
06549

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06547

1 DECEASED NAME (Type or print) First Middle Last Lena Kandler		2a DATE OF DEATH Month Day Year May 23, 1969		2b. HOUR 12 noon	
3 SEX female		4. RACE white		5 DATE OF BIRTH Sept. 19, 1883	
7a BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Baltimore		6 AGE (In years last birthday) 85 YRS		7 UNDER YEAR MONTHS DAYS HOURS M.N.	
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Seamstress	
12b. KIND OF BUSINESS OR INDUSTRY Aetna Shirt Co		13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. CITY OR TOWN Raspburg	
13c. COUNTY Balto.		3d. IS DE CITY J.M. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5006 Denview Way	
14 FATHER'S NAME First Middle Last Paul Kandler		15. MOTHER'S M.A.D.N. NAME First Middle Last Anna Hoffman			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO (If yes give war or dates of service) 217-05-4552A		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial insufficiency</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerotic coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Compression Fracture of T12</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21a ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 4:16 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fall from a chair	
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) At home		21f LOCATION Street or RFD No City or Town County State 5006 Denview Way Raspburg Balto- Md.	
22a. I certify that (I) (this hospital) attended the deceased from May 2, 1969 to May 23, 1969, that (I) (we) last saw the deceased alive on May 23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Fritz Koller M.D.		DEGREE M.D.		22c DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) FRITZ KOLLER M.D.		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore e, Maryland 21228			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/26/69		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison Street		ADDRESS		25a. REC'D BY REGISTRAR MAY 27 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06550

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06548

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sparks</u> c. LENGTH OF STAY IN 1D <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bellavista Farms/Dubbs Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sparks</u> d. STREET ADDRESS <u>Bellavista Farm/ Dubbs Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>M.</u> Last <u>Kavanagh</u>		4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1969</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 June 1881</u>
9. AGE (in years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thaddeus Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Martha Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>Family records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4124 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerotic</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>27-28</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>27 May 1969</u> to <u>27 May 1969</u> , that (I) (we) last saw the deceased alive on <u>5-16-1969</u> and that death occurred at <u>4:30 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M.C. Porterfield</u>		22b. DATE SIGNED <u>5-21-69</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		22d. ADDRESS <u>Hampstead, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/27/69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>John Burns Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MAY 29 1969
DATE

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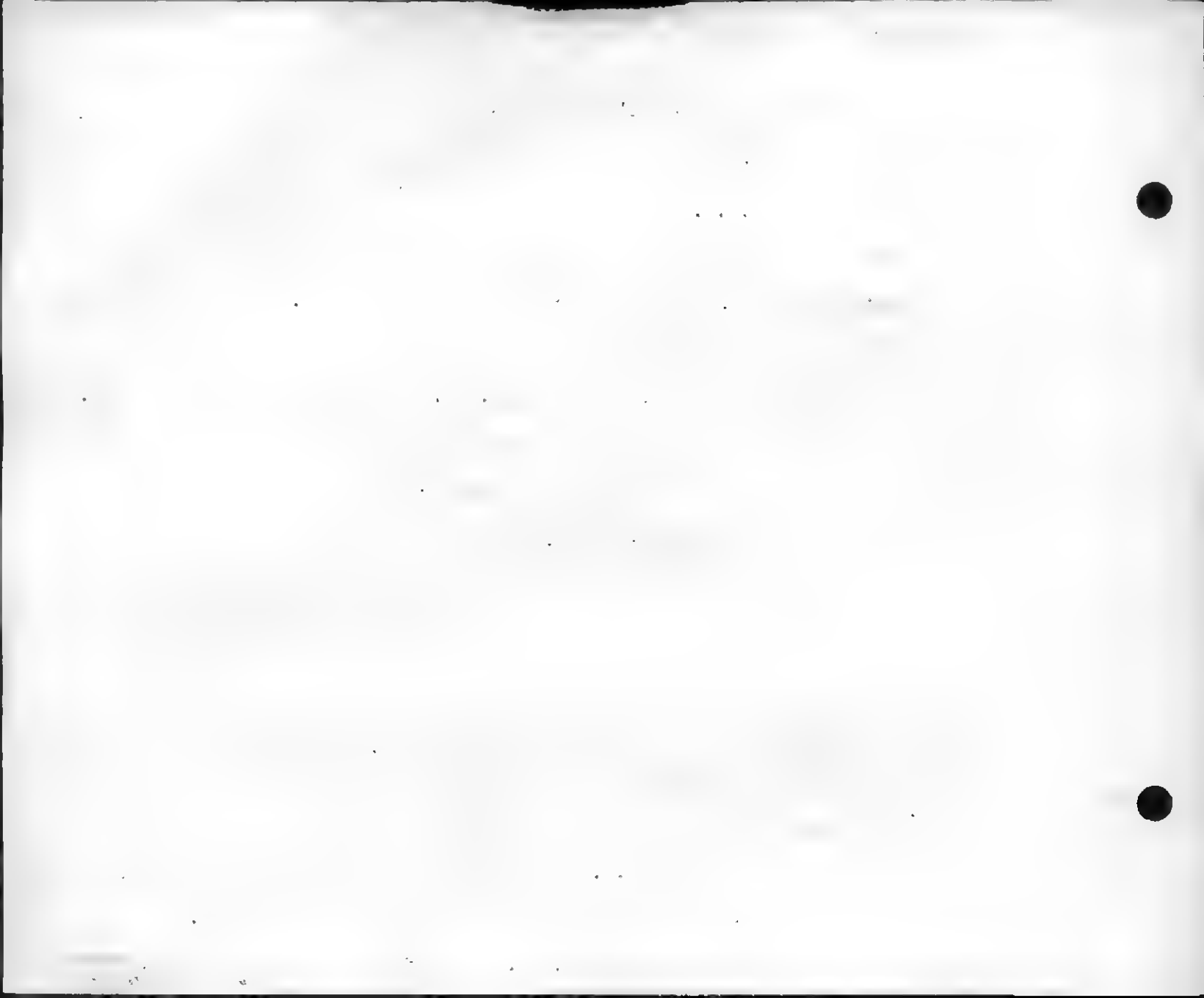
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR
#541
1969

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
ANDREW JACKSON KELBAUGH						MAY 23 1969			11:20PM				
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		7. UNDER 24 HRS		
Male		White		1/1/1900			69 YRS.		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland			U.S.A.						BALTIMORE			Md	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Fort Howard				Veterans Administration Hospital				Farmer				Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Baltimore		Parkton				Mt. Carmel Road			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
Louis Kelbaugh				Mary Stiffel									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address							
Yes WW II				212 26 7436		Clin. Rec. VA Hospital, Fort Howard, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOVASCULAR XXX ACCIDENT										WEEKS			
2509 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE										YEARS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DIABETES MELLITUS										YEARS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No City or Town County State							
22a. I certify that (this hospital) attended the deceased from May 19, 1969, to May 23, 1969, that (X) (we) lost the deceased alive on May 23, 1969, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Pushpendra Senan M.D.</i> DEGREE						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 5/24/69				
22d. PHYSICIAN'S NAME (Type) PUSHPENDRA SENAN, M.D.						22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			May 27, 1969		FORREST BAPTIST CEMETERY			PARKTON, MD.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE				
TIPTON ELINE FUNERAL HOME, HAMPSTEAD, MD.						MAY 28 1969			<i>Charles Judge</i>				

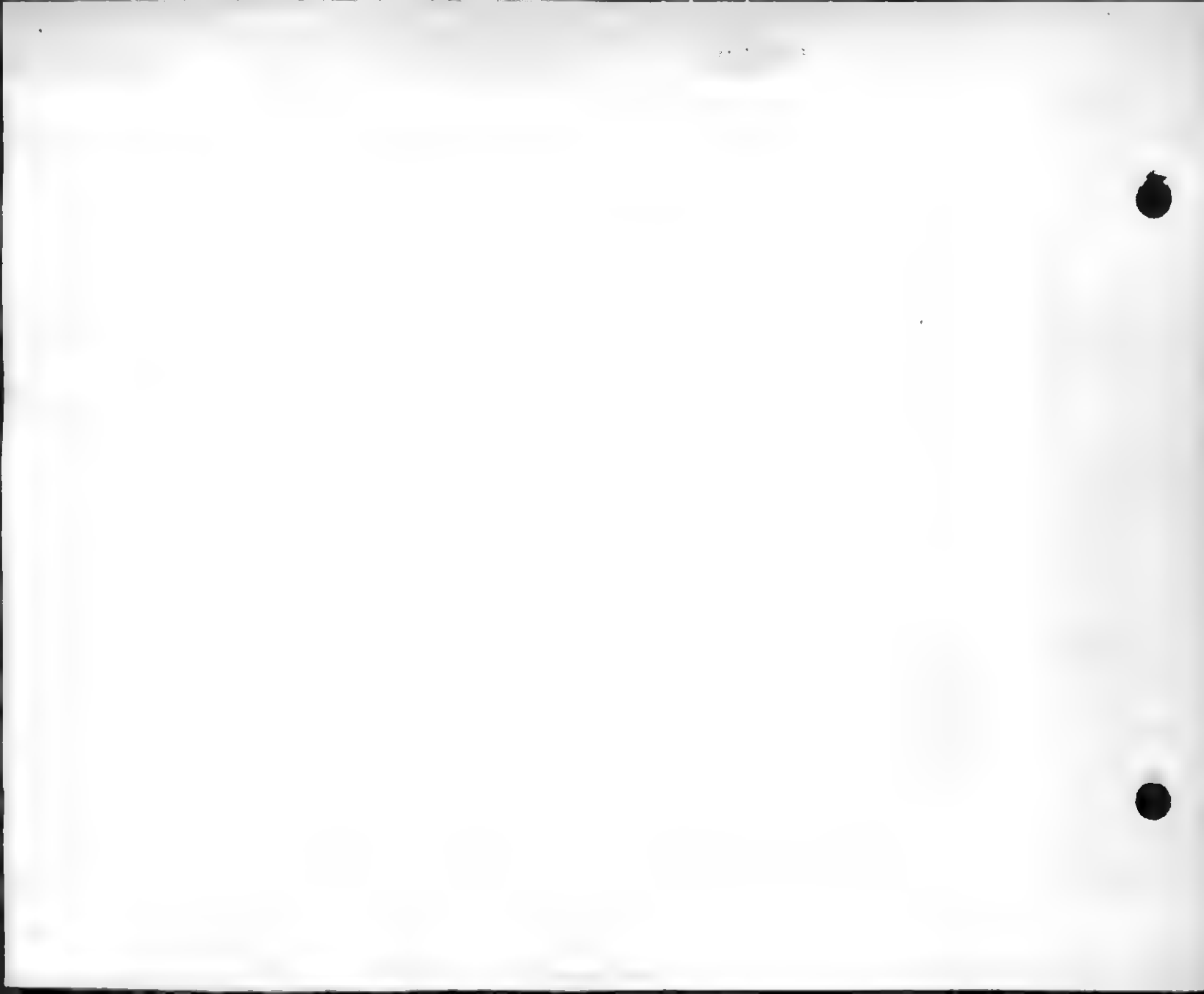


1. NAME OF DECEASED (Type or Print) HARRY T. KELLNER			2. DATE AND HOUR OF DEATH May 18, 1969		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Forest Haven Nursing Home, Inc.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Forest Haven Nursing Home, Inc.			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 603 S. Mason Street 3141 Dwyer Blvd. Ave.		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/1880	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) MD.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME August			14. MOTHER'S MAIDEN NAME Otten		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-05-6389		
			17. INFORMANT Mr. Edward Kellner		
			ADDRESS 603 S. Mason St.		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISSEMINATED M. TUBERCULOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BURSA DISSEMINATED M. TUBERCULOSIS URINARY DYSFUNCTION		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS		

22. I certify that (I) (this hospital) attended the deceased from 3/6 19 66 to 5/18 19 69 , that (I) (we) last saw the deceased alive on 5/18 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE John H. Shaw MD		23B. DATE SIGNED 5/19/69	
23C. PHYSICIAN'S NAME (Type) John H. Shaw MD		23D. ADDRESS 6801 Edmonson Ave. Balt 18, MD	
24A. BURIAL CREMATION REMOVAL (Specify) Burial	24B. DATE 5-19-69	24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	24D. LOCATION (City, town, or county) (State) Balto. MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

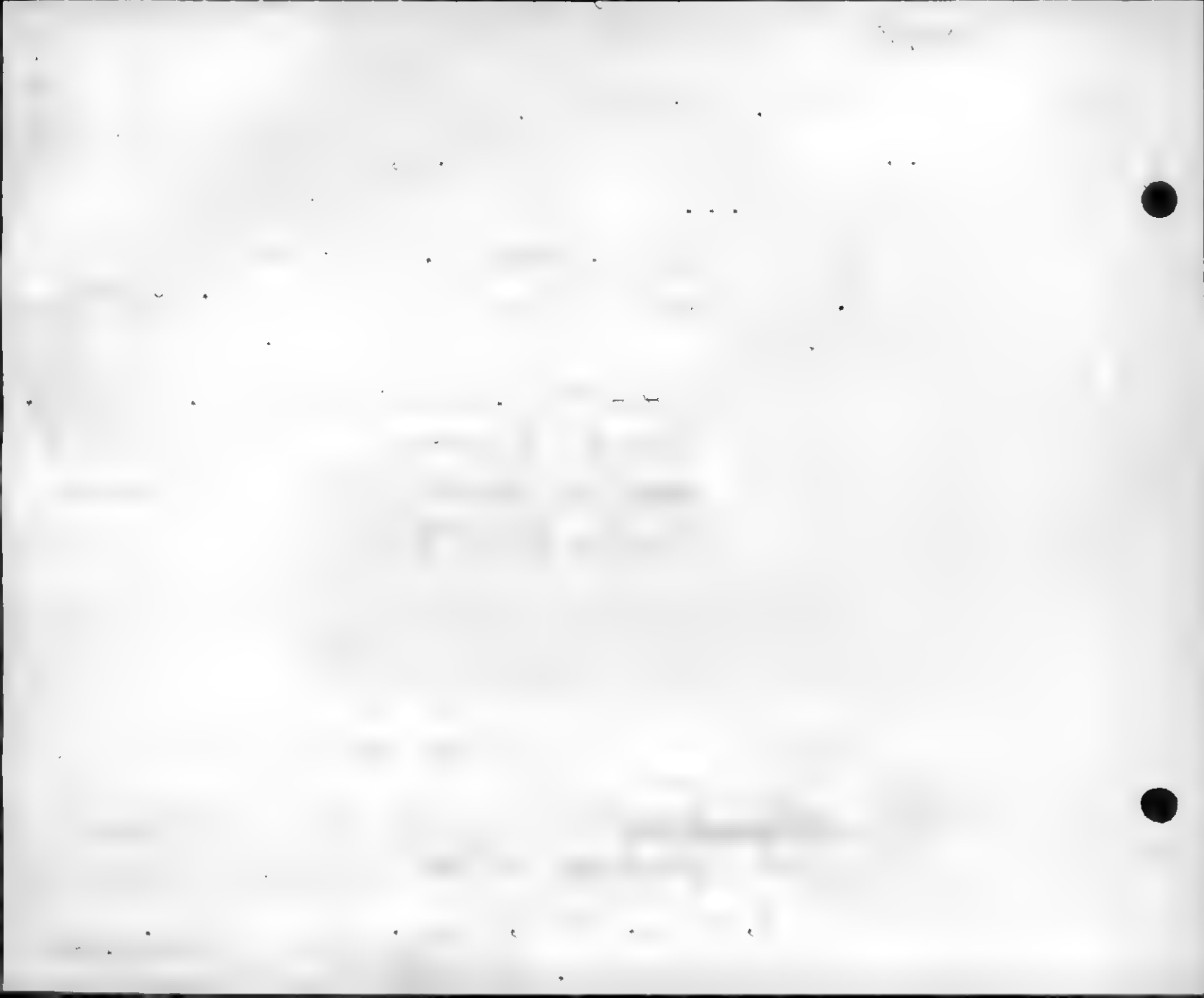
06553

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06551

1 DECEASED-NAME (Type or print) Kemp O. Nettie Nettie G. Kemp			2a DATE OF DEATH May Month 23 Day 69 Year			2b HOUR 7:20A M			
3 SEX F.M.		4 RACE White		5 DATE OF BIRTH Dec. 18, 1888		6 AGE (In years last birthday) 80		7 UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		10 UNDER 24 HRS HOURS MIN	
10 CITY OR TOWN OF DEATH Woodstock		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Offutt Rd. Woodstock Md.		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) House Wife		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Woodstock		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Offutt Rd. No Number	
14. FATHER'S NAME First Middle Last Roy A. Nicola				15 MOTHER'S MAIDEN NAME First Middle Last Burriss C. Mary					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b SOCIAL SECURITY NO 212040-5978		17 INFORMANT Address Mrs. Gladys Ridgley Offutt Rd. Woodstock Md.					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Thrombosis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES 10 YEARS 5 YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (the hospital) attended the deceased from OCT. 10, 1962 to MAY 23, 1969 , that (I) (we) last saw the deceased alive on 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE Edwin L. Pierpont, M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 5/23/69			
22d PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.				22e ADDRESS 8204 LIBERTY RD. - BALTIMORE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 27, 69		23c. NAME OF CEMETERY OR CREMATORY St. Michaels, Poplar Sp.		23d. LOCATION (City or Town) (County) (State) Poplar Springs Md.			
24. FUNERAL DIRECTOR Loring Byers Chapel 8728 Liberty Rd. Randallstown				25a REC'D BY REGISTRAR MAY 26 1969		25b REGISTRAR'S SIGNATURE [Signature]			

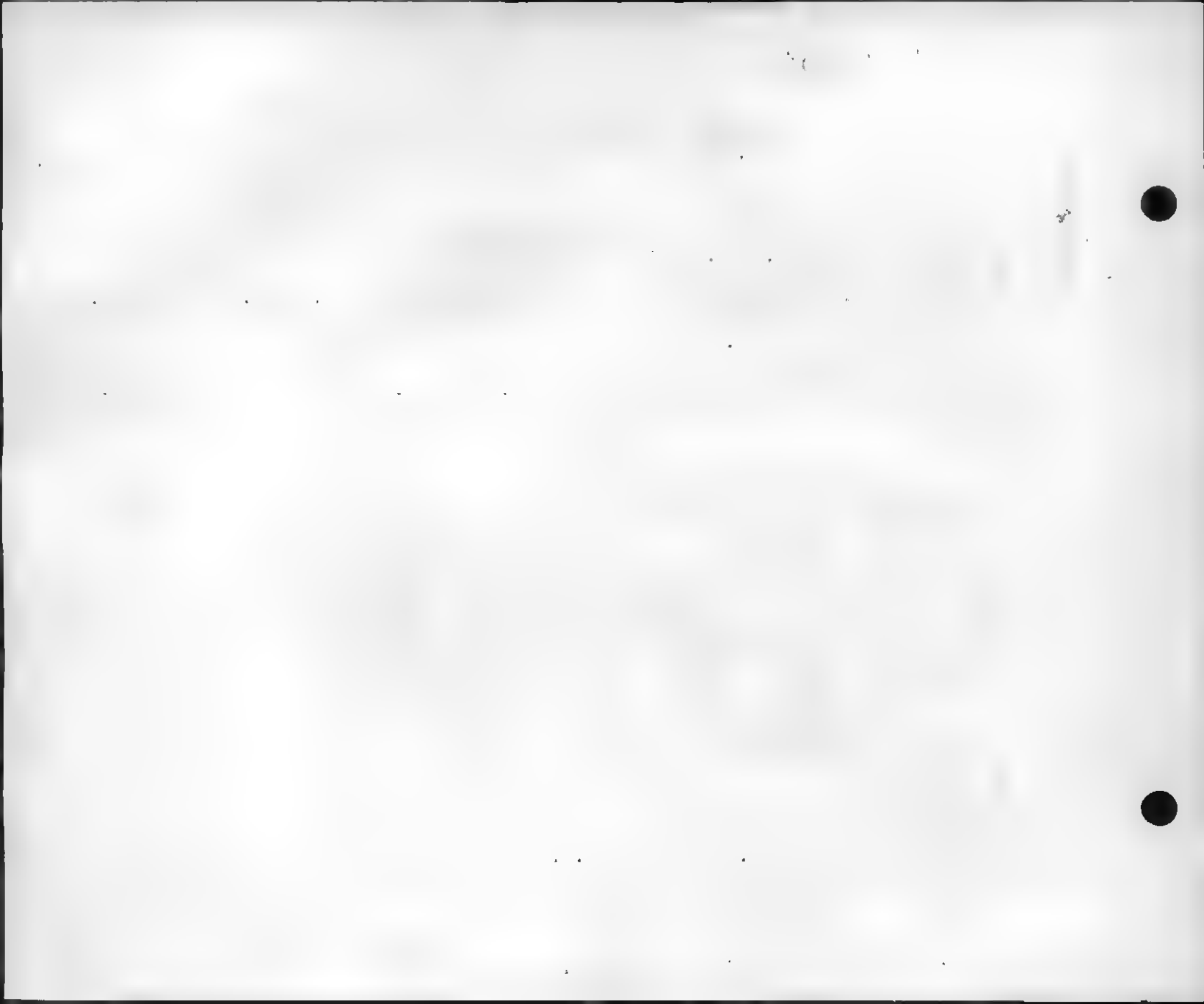


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 1 per tele. call DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 from F.H. 06554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or Print)			First JERRY			Middle ROBERT			Last KEARNS <i>Kerns</i>			2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <i>May 7 1969</i>			2b HOUR <i>M</i>		
3 SEX Male		4 RACE White		5. DATE OF BIRTH <i>Dec. 21, 1939</i>		6 AGE (in years last birthday) 29 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year <i>May 7 1969</i>			2d. HOUR <i>12:30 P.M.</i>		
7a BIRTHPLACE (State or foreign country) <i>Md.</i>				7b CITIZEN OF WHAT COUNTRY? <i>USA</i>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH BALTIMORE					
10. CITY OR TOWN OF DEATH Owings Mills				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) J. Bldg. Rosewood State Hospital								12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Insurance Man</i>				12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b COUNTY Baltimore				13c CITY OR TOWN Owings Mills				3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER J. Bldg. Rosewood St. Hosp.			
14. FATHER'S NAME First Middle Last <i>Bernard R. Kerns</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Katherine Campbell</i>													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b SOCIAL SECURITY NO (if yes give year or dates of service) <i>212-38-7218</i>				17. INFORMANT ADDRESS <i>Mrs. Peggy L. Kerns Owings Mills, Md.</i>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Charles S. Springate</i>				M.D. Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED May 8, 1969					
EXAMINER'S NAME (Type)				ADDRESS				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b DATE <i>May 10, 69</i>				23c NAME OF CEMETERY OR CREMATORY <i>Sunset Memorial</i>				23d LOCATION (City or Town) (County) (State) <i>Cumberland, Md.</i>					
24 FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i>								25a REC'D BY REG STRAR DATE MAY 12 1969				25b REG. STRAR'S SIGNATURE <i>Blair J. Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH			2b HOUR
HERMAN			-		-		KIESLING, JR		MAY 20, 1969			5:10 PM
3. SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR	
MALE			WHITE			4/13/12			57 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			12b KIND OF BUSINESS OR INDUSTRY
MARYLAND			U.S.A.						BALTIMORE			Shoe Shop
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			12c KIND OF BUSINESS OR INDUSTRY
FORT HOWARD			VETERANS ADMIN. HOSPITAL			SHOE REPAIRMAN						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INS. DE. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND			BALTIMORE			BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1812 MIDDLEBOROUGH ROAD	
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last
HERMAN			-		-		KIESLING		KATE			- - HORN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address			
YES			WWII						CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE AND PULMONARY EDEMA												
DUE TO, OR AS A CONSEQUENCE OF												
(b) HYPERTENSIVE CARDIOVASCULAR DISEASE												
DUE TO, OR AS A CONSEQUENCE OF												
(c) PEPTIC ULCER, MULTIPLE												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			HOUR A.M. Month Day Year P.M. 19									
21d INJURY OCCURRED			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION			Street or R.F.D. No City or Town County State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>												
22a I certify that (X) (this hospital) attended the deceased from MAY 18, 1969, to MAY 20, 1969, that (X) (we) last saw the deceased alive on MAY 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.												
22b SIGNATURE			22c. DATE SIGNED			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						5/20/69			
SUNG IL SHIN, M. D.			VAH, FT. HOWARD, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
BURIAL			5/22/69			BALTIMORE NATIONAL			BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Joseph N. Zannino			ZANNINO FUNERAL HOME			MAY 22 1969			John J. Judge			
			457 S. CONKLING ST. BALTIMORE, MD.									



1

06556

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06554

1 DECEASED NAME (Type or print) First Middle Last PRESTON M. KING			2a DATE OF DEATH Month Day Year 5 28 69			2b HOUR 9:00PM			
3 SEX MALE		4 RACE NEGRO		5 DATE OF BIRTH 3/9/21		6 AGE (In years last birthday) 48 YRS		7 UNDER YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			
10 CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VEI. ADM. HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CHAUFFEUR		12b KIND OF BUSINESS OR INDUSTRY TAXICAB			
13a U.S.A. RESIDENCE (Where deceased admission) STATE MARYLAND		13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY, APTS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3 2214 Eutaw Place	
14 FATHER'S NAME First Middle Last LEVIN KING			15 MOTHER'S MAIDEN NAME First Middle Last MARY WARD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b SOCIAL SECURITY NO WW 11		17 INFORMANT Address CLIN. RECORDS, VA HOSP. FT HOWARD, MARYLAND					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA 157.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF THE PANCREAS, METASTASIS, WIDESPREAD DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (a) (this hospital) attended the deceased from 3/4/69 , 19__, to 5/28/69 , 19__, that (b) (we) lost saw the deceased alive on 3/28/69 , 19__, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Sung Il Shin</i>								22c DATE SIGNED 5/29/69	
22d PHYSICIAN'S NAME (Type) SUNG IL SHIN, M.D.				22e ADDRESS VAH FORT HOWARD, MARYLAND					
23a BURIAL, CREMATION, DISPOSAL (Specify) BURIAL		23b DATE 6-4-69		23c NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY		23d LOCATION (City or Town)		(County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR ELROY WILSON FUNERAL HOME				ADDRESS 2004 ORLEANS ST., BALTO., MD.		25a REC'D BY REGISTRAR DATE JUN 5 1969		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1579

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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06557

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06555

Item 414, Film 413 6/2/69 km

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Elsie		nmi		Kirby	05 Month 22 Day 69 ^{Year}		10:45 M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birth day)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female	White		3-4-91		78 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CIT. ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore	USA				Baltimore		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Randallstown		Baltimore Co General		House Wife				
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. NO. OF CITY, JAIL, ST		13e. STREET AND NUMBER
Md.		Balto		Randallstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8603 Allenswood Rd.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Henry Clark		William	Walton	Kirby	Mary E. (Sheldon)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO		213-05-9155 B		Mrs. Patricia Christ		8603 Allenswood Rd.		
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE								
<p>Presenting acute thromboses</p> <p>44 a</p> <p>Due to, or as a consequence of</p> <p>A Gangrene of the small & large</p> <p>Due to, or as a consequence of</p> <p>Generalized arteriosclerosis</p>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes		
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work								
22a. I certify that (I) (this hospital) attended the deceased from 5-22, 19 69, to 5-22, 19 69 that (I) (we) lost saw the deceased alive on 5-22, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
Loring Byers								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		May 26, 69		Lake View Memorial Park		Liberty Rd. Carroll Co. Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Loring Byers		8728 Liberty Rd. Randallstown		MAY 26 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

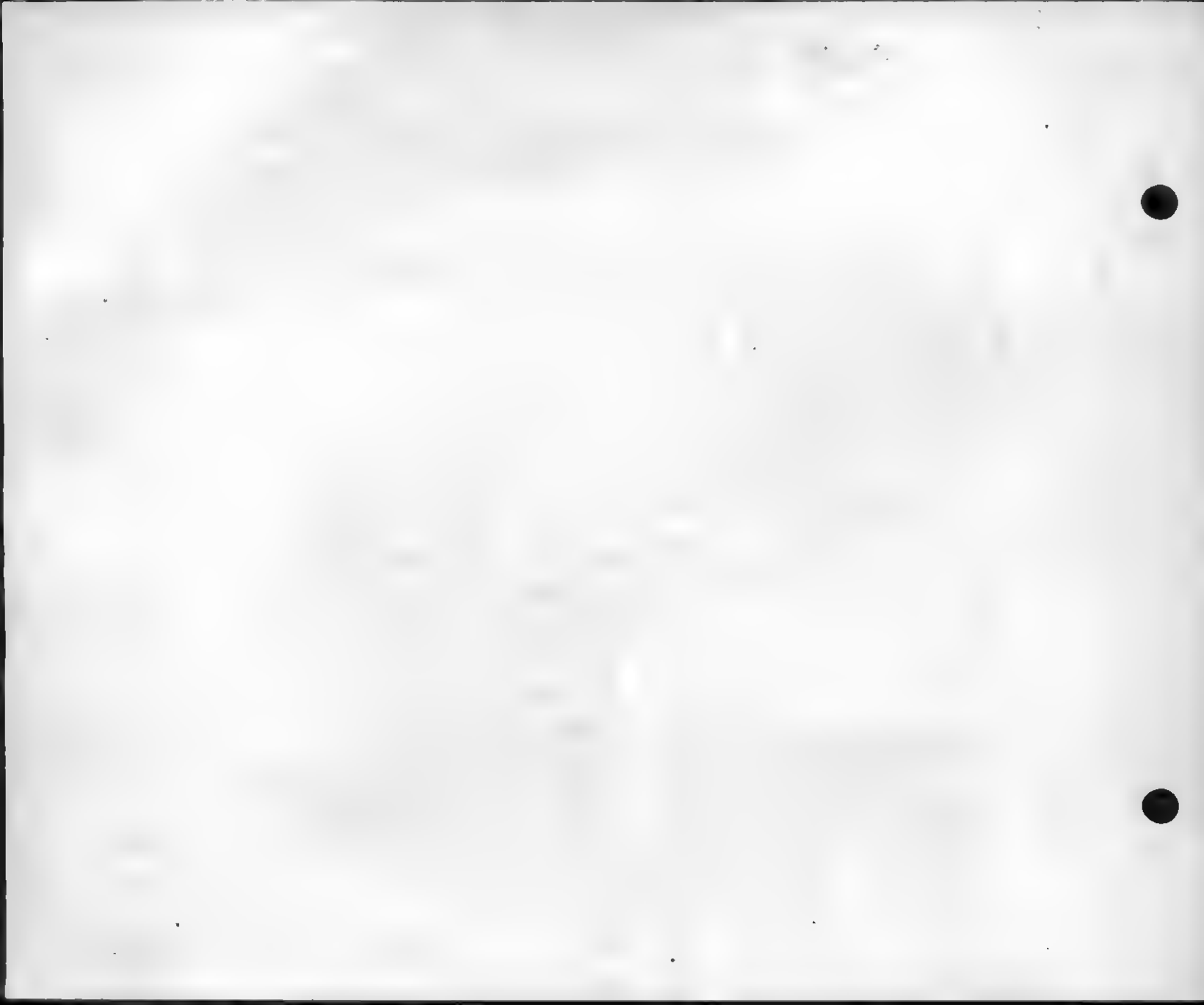
TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
2
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
06558 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06556

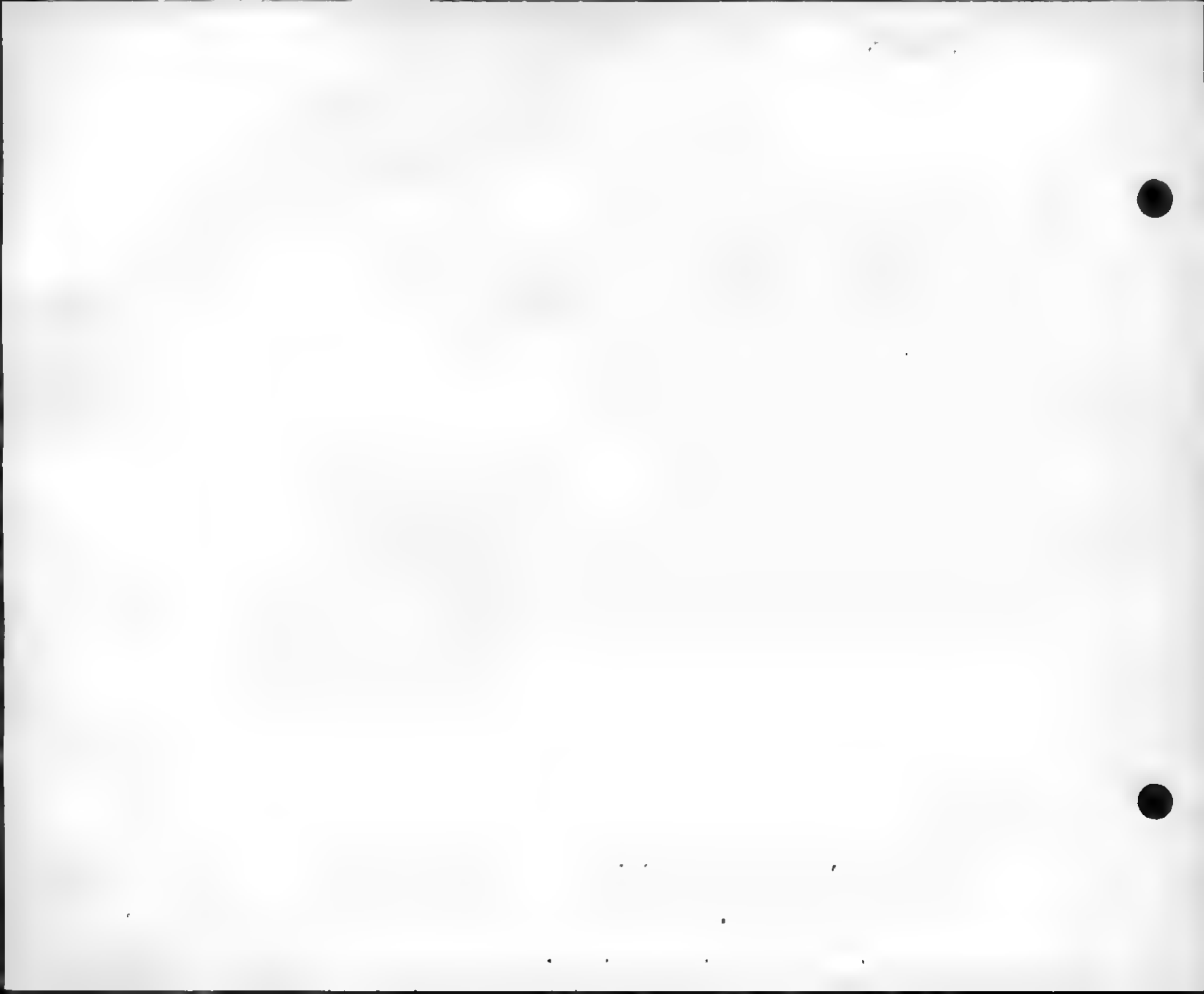
1. DECEASED NAME (Type or Print) BERTHA First MAY Middle KIRCHER Last		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI <input type="checkbox"/> MATED 5-6 Month 1969 Year		2b. HOUR 1300 M
3. SEX F	4. RACE W	5. DATE OF BIRTH 5-13-03	6. AGE (In years last birthday) 65 YRS	7. UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTO.
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5915 MONTGOMERY		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) housewife
13a. USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE MD		13b. COUNTY Balto	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY, ALTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME Henry First K Middle KETTLEBAND Last		15. MOTHER'S MAIDEN NAME Dieter First K Middle KETTLEBAND Last		16. ADDRESS 5915 MONTGOMERY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO 213-34-3323		17. INFORMANT MARY E. WILLIAMS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 INHOURS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				A. C. U. H. D
(b) DUE TO, OR AS A CONSEQUENCE OF				1 YR.
(c) DUE TO, OR AS A CONSEQUENCE OF				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
DIABETES MELLITUS. TOTAL BLINDNESS				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE John F. Schaefer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/6/69
EXAMINER'S NAME (Type) JOHN F. SCHAEFER M.D.		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/9/69	23c. NAME OF CEMETERY OR CREMATORY Western Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave.,		ADDRESS 21229	25a. REC'D BY REG STRAR MAY 8 1969	25b. REG-STRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

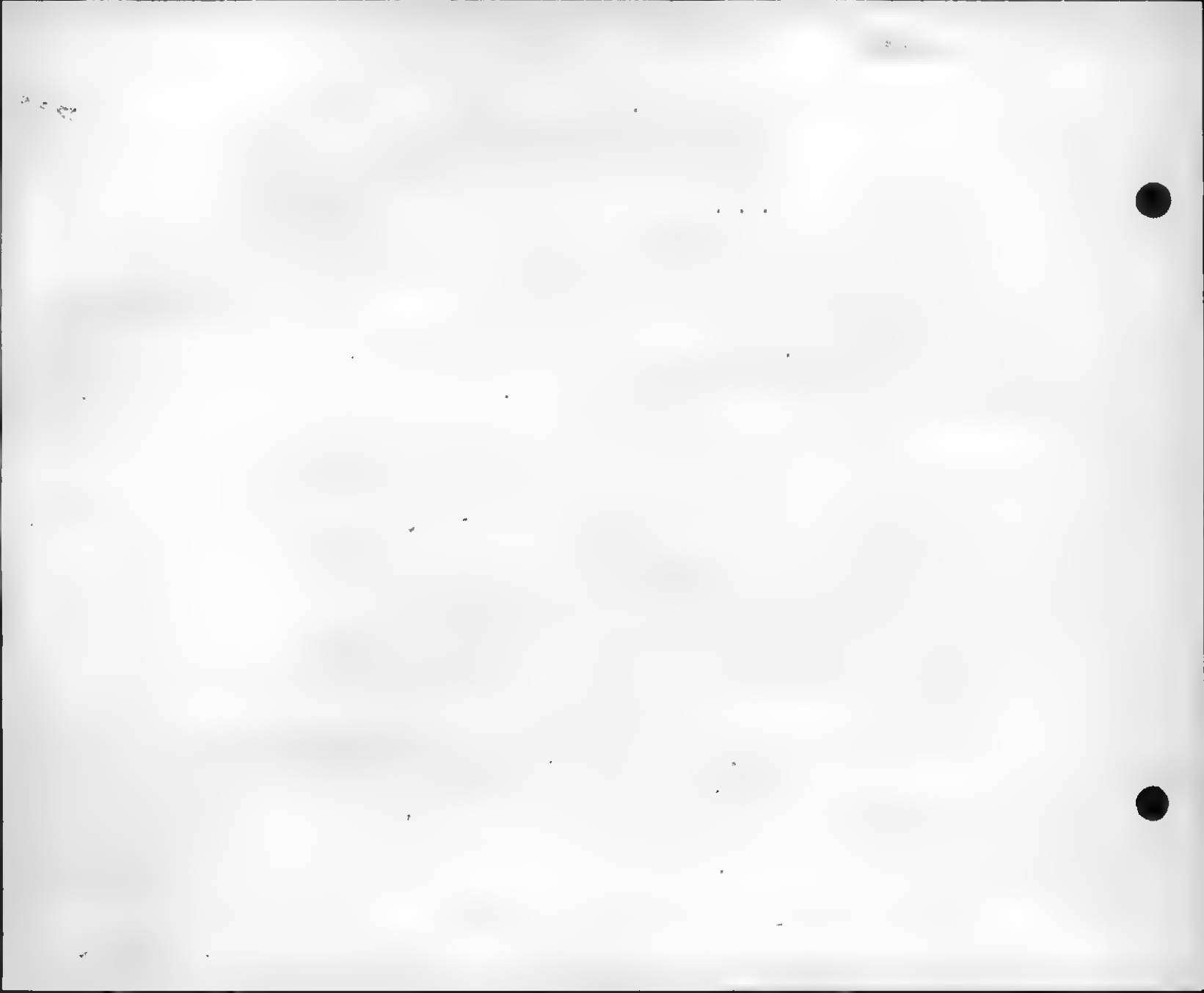
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06559					06557						
1. DECEASED NAME (Type or print) Sara AGNES					First Kirsch		Last		20. DATE OF DEATH Month MAY Day 28 Year 1969		
3 SEX F		4 RACE W		5 DATE OF BIRTH 7/7/1891			6 AGE (In years lost birthday) 77 YRS		2b HOUR 12:05AM		
7a BIRTHPLACE (State or foreign country) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8-MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			Md		
10 CITY OR TOWN OF DEATH TOWSON			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) STELLA MARIS HOSPICE			12a U.S.A. OCCUPATION (Kind of work done during most of work ng life, even if ret red) SEWING OPERATOR			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if instital on Residence before admission) STATE MD			13b. COUNTY BALTO.		13c CTY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 8416 Loch RAVEN Blvd.		
14 FATHER'S NAME First Joseph A Middle GREELEY Last					15 MOTHER'S MAIDEN NAME First MARY E. Middle SHERRY Last						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO 216-20-4953-A		17 INFORMANT Address STELLA MARIS HOSPICE - Towson Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ASCVD - DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr -	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JULY , 19 68 , to MAY , 19 69 , that (I) (we) last saw the deceased alive on MAY 27 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE E Lee Robbins					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 5/28/69				
22d. PHYSICIAN'S NAME (Type) E. Lee Robbins, M.D.					22e. ADDRESS 812 Hookinbird Lane						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/31/69.		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, inc. Balto. Md. 21214					25a. REC'D BY REGISTRAR DATE JUN 2 1969		25b. REGISTRAR'S SIGNATURE Richard Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First RUBY		Middle B.		Last KITCHEN		2a. DATE OF DEATH May Month 31, Day 1969		2b. HOUR 7:30
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9-12-1886		6. AGE (In years lost birthday) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 1 YRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Halethorpe		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1802 Woodside Avenue				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Halethorpe		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1802 Woodside Avenue		
14. FATHER'S NAME First Middle Last Robert H. Heath				15. MOTHER'S MAIDEN NAME First Middle Last Dora T. Hubert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 217-01-7800B		17. INFORMANT Mr. Ardelle Kitchen, 1802 Woodside Ave. 21227		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular disease										5/9/69
DUE TO, OR AS A CONSEQUENCE OF (b) hypertension										5/9/69
DUE TO, OR AS A CONSEQUENCE OF (c) chronic heart failure, chronic bronchitis										3 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (1) (this hospital) attended the deceased from 6/24/69 to 6/31/69 , that (we) last saw the deceased alive on 6/31/69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.										
22b. SIGNATURE B. Brumbaugh M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/2/69				
22d. PHYSICIAN'S NAME (Type) Dr. Bruce B. Brumbaugh		22e. ADDRESS 5609 Main Street, Elkridge, Md.								
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-3-1969		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 5 1969		25b. REGISTRAR'S SIGNATURE Howard H. Hubbard				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) JOSEPH STANISLAW KLESZCZEWSKI					2a. DATE OF DEATH Month 5 Day 17 Year 69		2b. HOUR 11:40 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7.4.1901		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.				
10. CITY OR TOWN OF DEATH Mount Wilson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Storekeeper		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.			13b. COUNTY Fredrick		13c. CITY OR TOWN Cullen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Victor Cullen State Hosp.	
14. FATHER'S NAME First FRANK Middle KLESZCZEWSKI Last MARIE			15. MOTHER'S MAIDEN NAME First MARIE Middle SWININKA Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 215-10-8283A		17. INFORMANT Address Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral-vascular accident 4-6-0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary tuberculosis. Hypertensive cardio-vascular disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ P.M. _____ Month _____ Day _____ Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____ State _____		
22a. I certify that (I) (this hospital) attended the deceased from 6.25. 1965 to 5.17. 1969 , that (I) (we) last saw the deceased alive on 5.17. 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE William Newcomer					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5.17. 1969			
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.					22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/21/69		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.				
24. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI					ADDRESS 2525 FLEET ST.		25a. REC'D BY REGISTRAR DATE 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

06562

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06560

1 DECEASED NAME (Type or Print) JOSEPH Mc Russell KNIGHT			2a DATE KNOWN OF ESTI- DEATH MATED 5-31-69			2b HOUR 12:45 AM		
3 SEX M	4 RACE C	5 DATE OF BIRTH 5-6-1900	6 AGE (in years last birthday) 69 YRS	IF UNDER 1 YEAR MONTHS 5 DAYS 31	IF UNDER 24 HRS HOURS 12 MIN 45	2c DATE PRONOUNCED DEAD Month 5 Day 31 Year 1969		2d HOUR 12:45 AM
7a BIRTHPLACE (State or foreign country) VA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Baltimore County Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SALTIMORE CO. GEN			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Baltimore	13d HOME CITY (If 13c YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 1714 Wolfe St 21213	
14 FATHER'S NAME First WILLIE Middle ALFRED Last KNIGHT			15 MOTHER'S MAIDEN NAME First JENNIE Middle ANN Last MOTLEY			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) NO		
16b. SOCIAL SECURITY NO.			17 INFORMANT Sister Mrs. Margaret Barnes			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18 CAUSE OF DEATH (Enter on y one cause per ne for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease. DUE TO, OR AS A CONSEQUENCE OF (b) (Gastric Disease) DUE TO, OR AS A CONSEQUENCE OF (c) 411 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Since 1963 Since 1953
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) In 1967 at GHH given Cabalt treatment for gastric disease and abdominal operation								
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month Day, Year HOUR A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Robert Bruce Taylor MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 5-31-69		
EXAMINER'S NAME (Type) Robert Bruce TAYLOR			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a BURIAL CREMATION, OR REMOVAL (Specify)		23b DATE 6/4/69		23c NAME OF CEMETERY OR CREMATORY MT-CALVARY		23d LOCATION (City or Town) (County) (State) A.A. Co. Md.		
24 FUNERAL DIRECTOR Charles B. Lewis		ADDRESS 839 Mt. Holly St.		25a REC'D BY REGISTRAR JUN 6 1969		25b REGISTRAR'S SIGNATURE Charles Lewis		

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1055 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

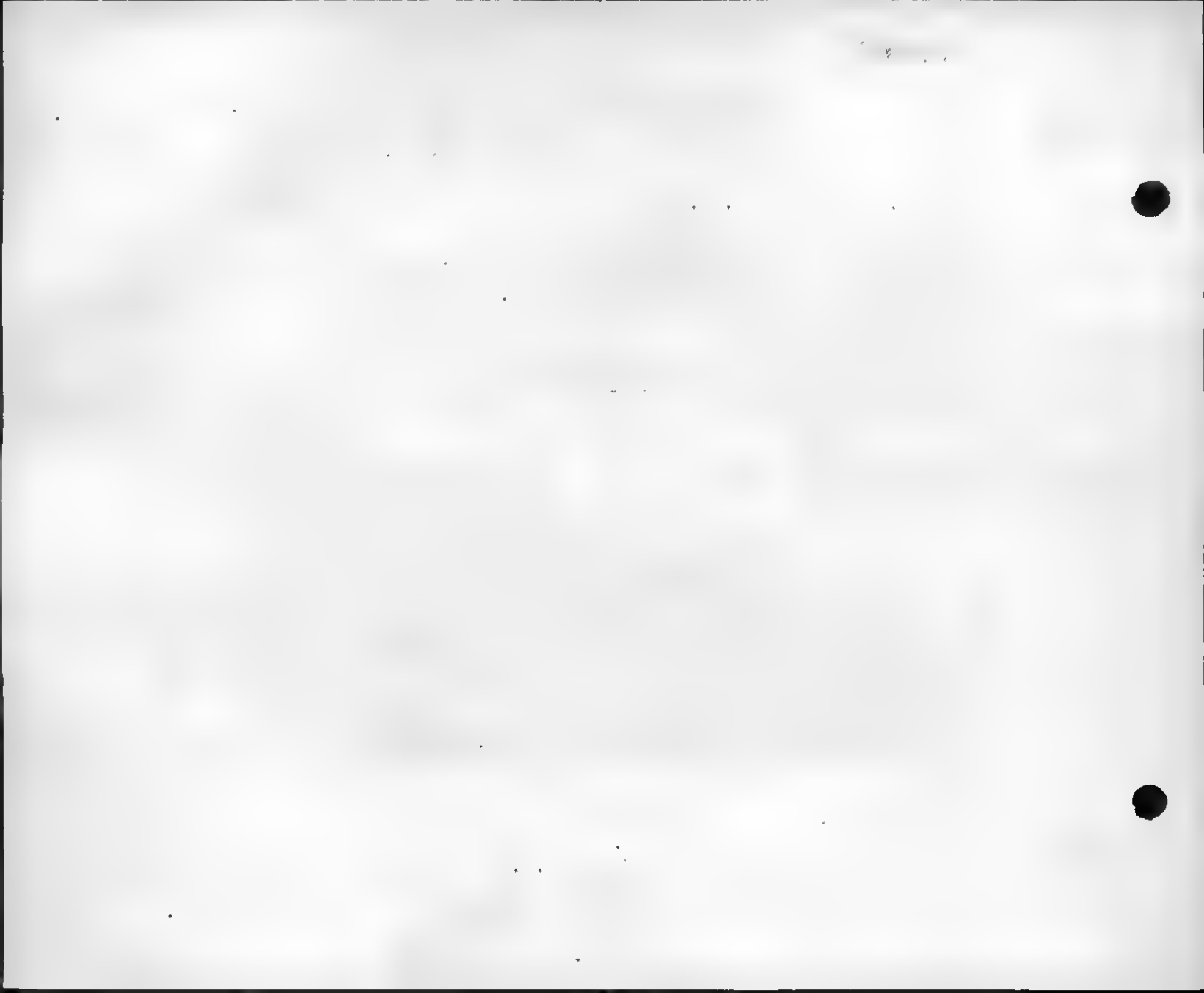


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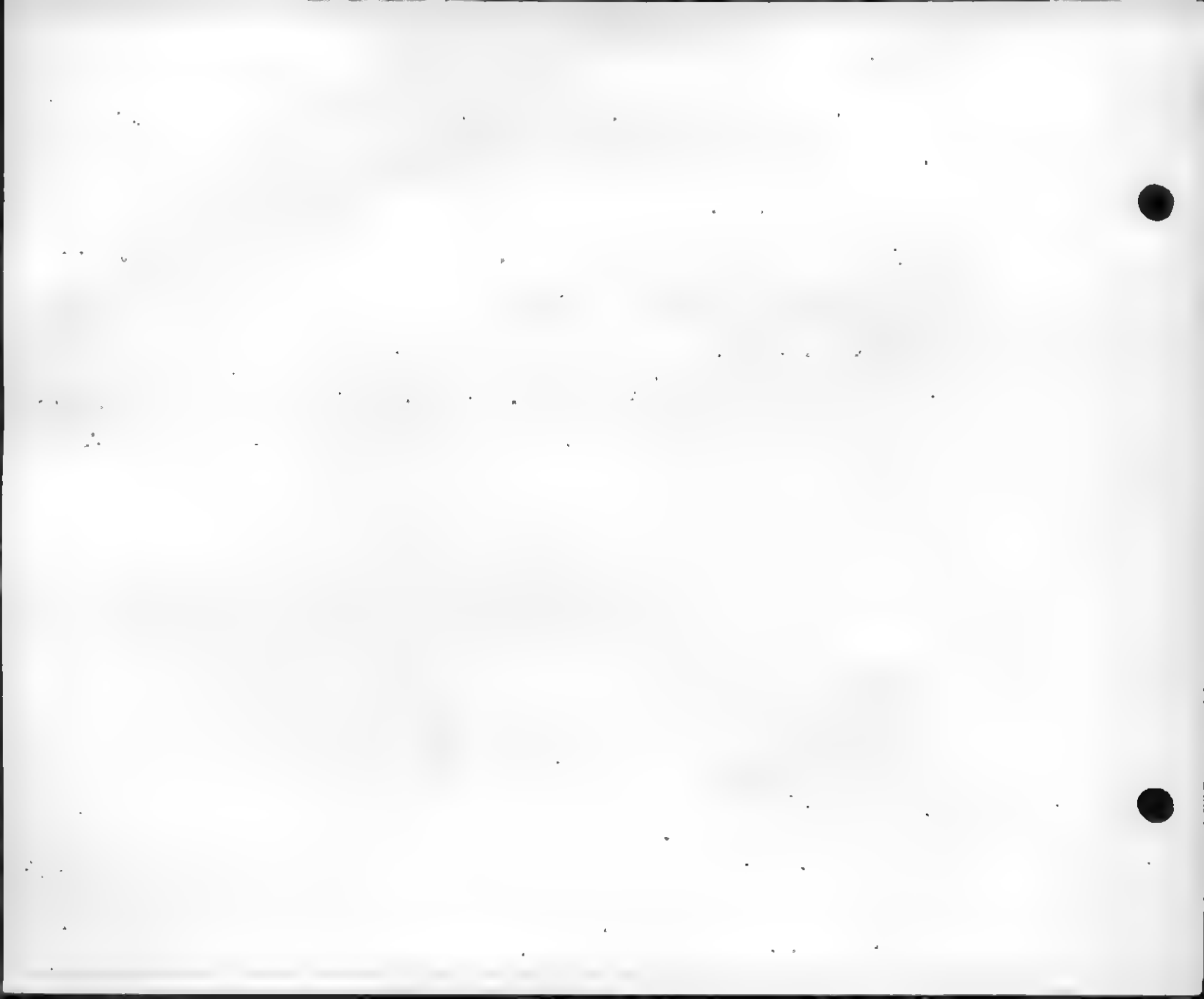
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
Marie Amalie Seuchting Korff						May 16, 1969		12:50 a.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
female		white		Nov. 13, 1877		91 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Md.		U. S.				Baltimore		Md.	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Catonsville			SPRING GROVE STATE HOSP.			housewife			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.						Balto.		3916 Maine Avenue	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
William Seuchting			Marie Mueller						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown			16b SOCIAL SECURITY NO.			17 INFORMANT Address			
No			219-54-3195			Records: SPRING GROVE STATE HOSPITAL			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									
4124 DUE TO, OR AS A CONSEQUENCE OF									
Congestive heart failure									
(b) DUE TO, OR AS A CONSEQUENCE OF									
Heart block									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Decubitus ulcers									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from Nov. 21, 1966, to May 16, 1969, that (I) (we) last saw the deceased alive on May 16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE Diomidis L. Pirovolidis M.D. DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 5-16-69		
22d PHYSICIAN'S NAME (Type) Diomidis L. Pirovolidis, M.D.					22e ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 5/17/69		23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24 FUNERAL DIRECTOR ADDRESS Ann Donovan-3818 Roland Ave.					25a REC'D BY REGISTRAR MAY 19 1969		25b REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P.M.		
Edna			Louise			Kraft			May 16 1969 7:30 P.M.		
3 SEX			4. RACE			5 DATE OF BIRTH			6 AGE (in years lost birthday)		
female			white			May 28, 1882			36 YRS.		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D.VORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Maryland			U.S.A.						Baltimore Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			Shady Nook Nurs. Home			housewife			at home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Maryland			Howard			Ellicott City			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e STREET AND NUMBER					
Charles H. Schotta			Caroline Schweinsberg			Church Rd.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			720-44-2384			Dr. Thomas F. Herbert			Church Rd, Ellicott City Md 21043		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that (1) (this hospital) attended the deceased from <u>July 12, 1957</u> to <u>May 16, 1969</u> , that (1) (we) lost saw the deceased alive on <u>May 16, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Thomas F. Herbert, M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>								22c DATE SIGNED <u>5-17-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Thomas F. Herbert M.D.</u>								22e ADDRESS <u>3779 Church Rd, Ellicott City, Md 21043</u>			
23a BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		5/19/1969		St. Johns		Ellicott City, Howard				Md.	
24 FUNERAL DIRECTOR <u>Alginbotham Slack</u> ADDRESS <u>Ellicott City, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>MAY 20 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Michaela J. ...</u>			



1
12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06565
CERTIFICATE OF DEATH
06563

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>37 Haddington Road</u>		d. STREET ADDRESS <u>37 Haddington Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>A</u> Last <u>Kramer Jr.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1969</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 Aug. 1914</u>
9. AGE (in years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paint Company</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles A. Kramer Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Louise Dressel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u> <u>WW2</u>		16. SOCIAL SECURITY NO. <u>215-07-4098</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Benign essential hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Nov. 1968</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>November 8, 1968</u> , to <u>May 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>May 5, 1969</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Donald O. Wood</u>		22b. DATE SIGNED <u>5-7-69</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD O. WOOD, M.D.</u>		22d. ADDRESS <u>York Rd. and Greenmeadow Dr., Timonium</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/8/69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR <u>John Burns Sons</u>		25a. REC'D BY REGISTRAR <u>Tolson, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 12 1969</u>	

9-11-19

10-11-19

11-11-19

12-11-19

13-11-19

14-11-19

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25-11-19

26-11-19

27-11-19

28-11-19

29-11-19

30-11-19

1-12-19

2-12-19

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>06566</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>06564</div>												
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH				2b. HOUR		
FRED MORRIS KRAMER						<input checked="" type="checkbox"/> Month Day Year 5 28 1969				12:20		
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR
Male	White	March 7, 93	76 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year May 28 19 69				12:00
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH						
California		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.						MD
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Woodlawn			Holiday Health Club			retired			Architect			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
DC.			N			Washington D.C.				3128 Westover Dr. SE.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
George Kramer			Marie Strohimer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS						
No						Daly City Irvin Kramer-231-Acton St. California						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease												
4124 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			19									
22. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			May 28, 1969			
Edward F. Wilson, M.D.						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. CREMATION, (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
			May 31-1969			Cedar Hill Crematory			Suitland, Maryland			
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR			
Simmons Bros.						Wash. D.C.			JUN 2 1969			
									25b. REGISTRAR'S SIGNATURE			
									Charles Judge			

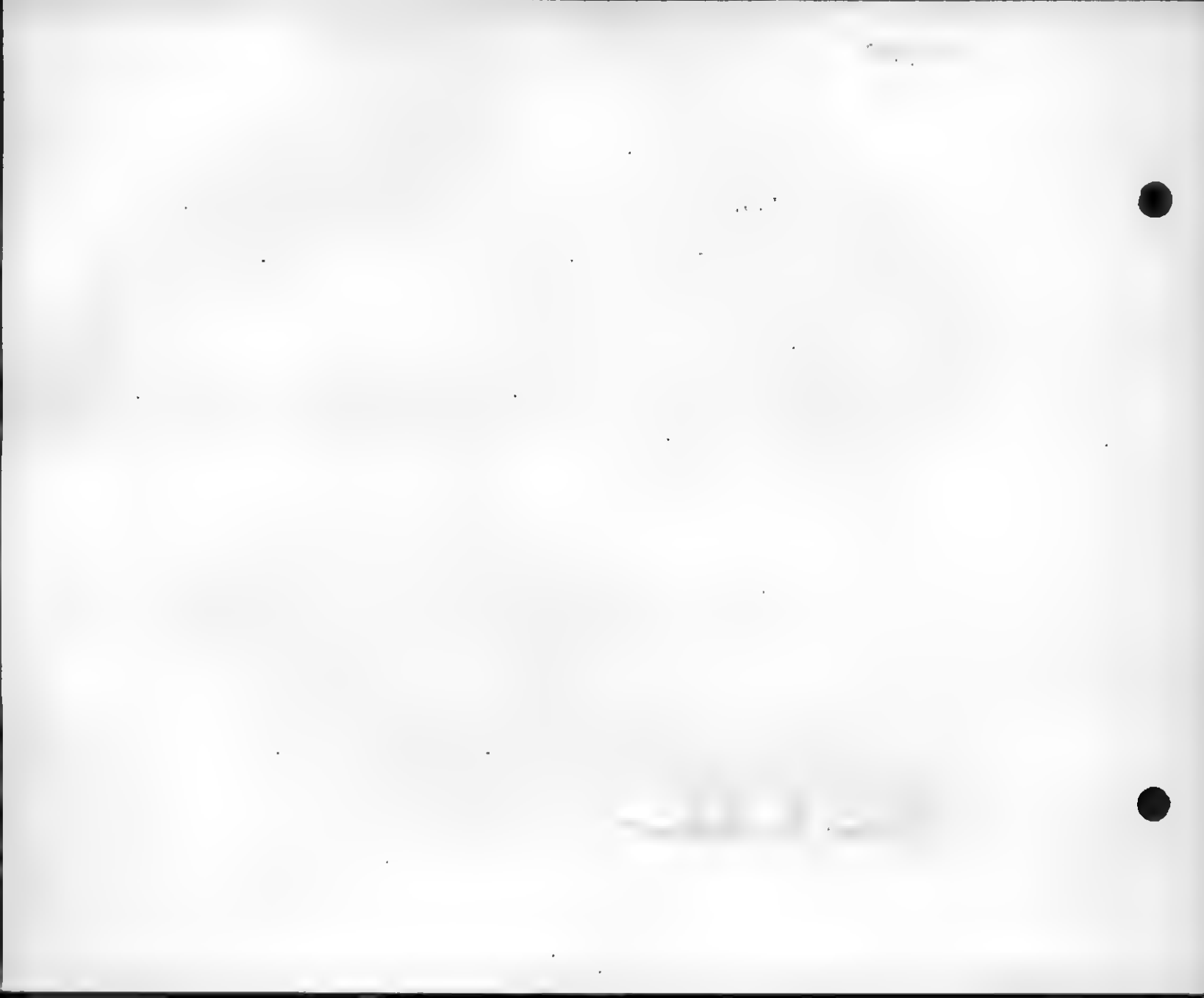


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
45M

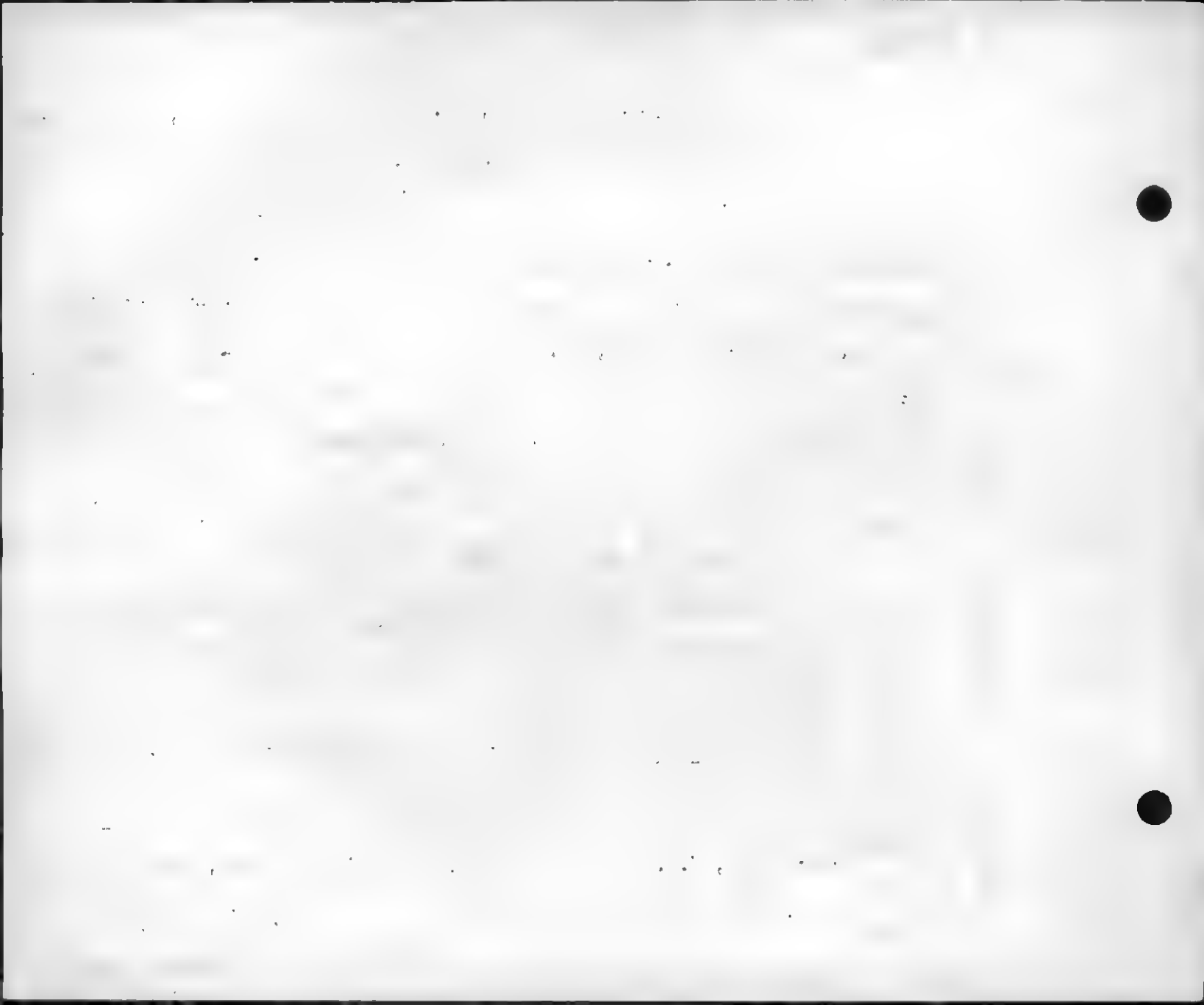
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Emma			C.		Krauss	5 Month 7 Day 69 Year			3:35P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR MONTHS DAYS	
Female		Caucasian		5/14/04		64 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Towson			Greater Balto. Med. Center			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Towson			601 St. Francis Road	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
William Henry Keigler					Mary Heer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
No			212-09-0173B		W. Kemp Lehmann 601 St. Francis Rd. 21204				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary embolus and carcinoma of breast									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>69</u> , to <u>5/7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John E. Adams</i>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/8/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>John E. Adams, M.D.</u>						22e. ADDRESS <u>6701 N. Charles Street</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-10-1969		Dulaney Valley Memorial		Cockeysville, Maryland			
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks</u> <u>Towson 1050 York Rd. 21204</u>						25a. REC'D BY REGISTRAR <u>DATE MAY 12 1969</u>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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Item 18 Film 413 6-10-69 MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06568 Item #2a, Film 413 7/15/69 km CERTIFICATE OF DEATH 06566									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR A
Thomas Joseph LaCotti, Jr.						May 28, 1969			12:05
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 YRS. MONTHS DAYS
Male		White		March 26, 1969			3		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		USA					Baltimore Md		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Towson			St. Joseph Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
Maryland			BALTO		Baltimore				303 Patapsco Ave. 21237
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Thomas Joseph LaCotti, Sr.			Beverly Ruth Schueler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
No					Parents - same address				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> (Meningitis) DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hemophilus influenza</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-28</u> , 19 <u>69</u> , to <u>5-29</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Jose Aguto</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED <u>5-29-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Jose Aguto, M.D.</u>						22e ADDRESS <u>7620 York Road, Towson, Maryland 21204</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		5/31/69		GARDENS OF FAITH		BALTO. MD			
24 FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
J.G. CONNELLY SONS 300 MACE				JUN 3 1969		<u>Richard Judge</u>			

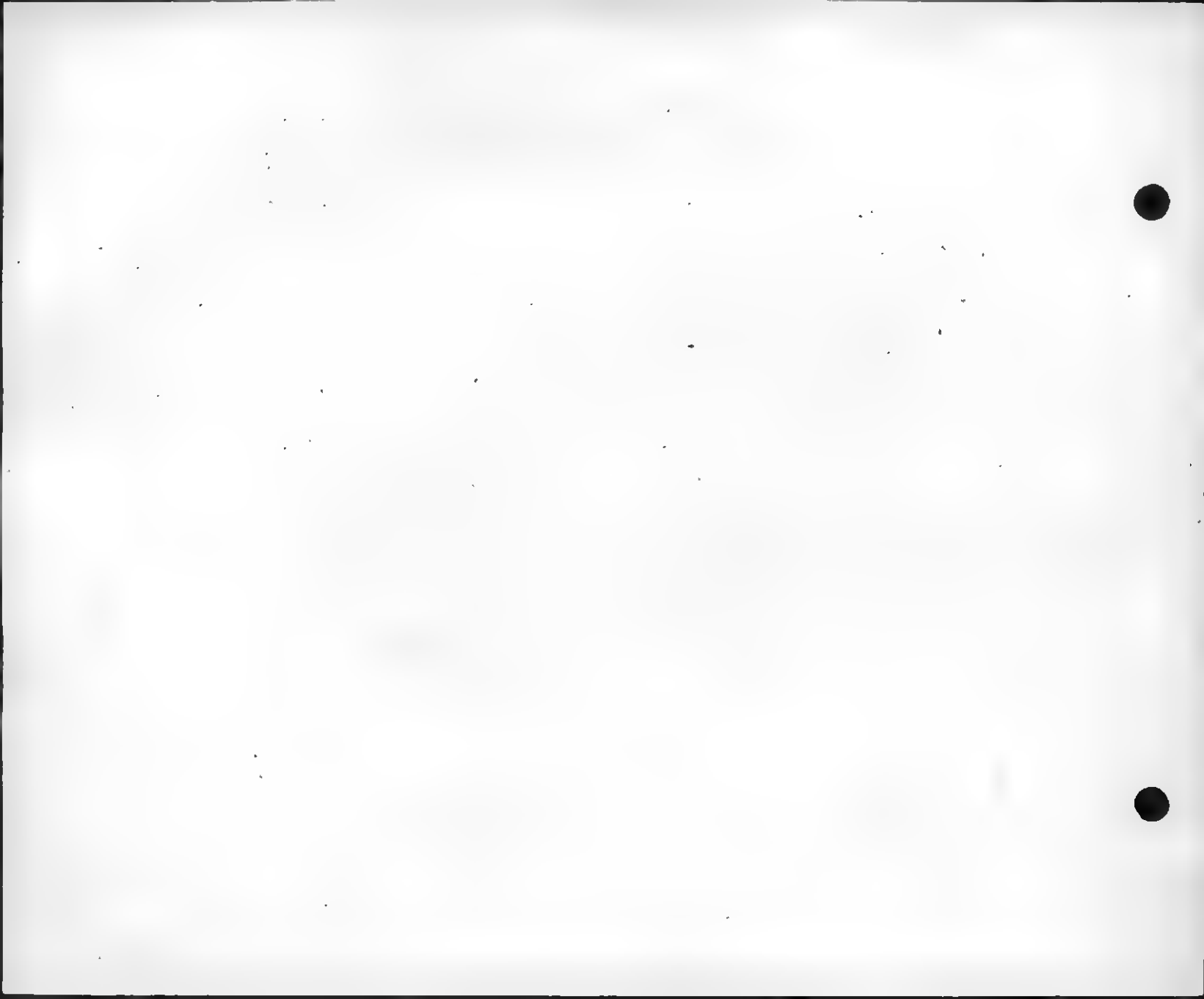


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VR A13 (4)
304 REV. 5-69

<div>4</div> <div>1</div> <div>06569</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06567</div>									
1 DECEASED NAME (Type or print) NICHOLAS ELMER LE COMPTE, SR.					2a. DATE OF DEATH Month May Day 29 Year 1969			2b. HOUR M	
3 SEX M		4 RACE W		5 DATE OF BIRTH 9-28-1885		6 AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md			
10. CITY OR TOWN OF DEATH BALTIMORE			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 547 SENECA PK. RD.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY WAS ELECTRIC	
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c CITY OR TOWN BALTO.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 547 SENECA PK. RD.	
14. FATHER'S NAME First Middle Last JOSHUA LE COMPTE				15. MOTHER'S MAIDEN NAME First Middle Last JOSEPH TURNER					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO -		17 INFORMANT Address Mrs. Helen Orr - 547 Seneca Park Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Strengthenedtherosclerosis DUE TO, OR AS A CONSEQUENCE OF Dissecting aortic aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb , 19 67 , to May , 19 69 , that (I) (we) lost the deceased alive on May , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE Robert J. Lyden M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-31-69			
22d. PHYSICIAN'S NAME (Type) Robert J. Lyden, M.D.		22e. ADDRESS 6402 Golden Ring Road							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-2-69		23c. NAME OF CEMETERY OR CREMATORY EAK HAWK CEM.		23d. LOCATION (City or Town) (County) (State) BALTO. Md.			
24 FUNERAL DIRECTOR Arthur Weller		ADDRESS 2334 Jefferson St.		25a. REC'D BY REGISTRAR DATE 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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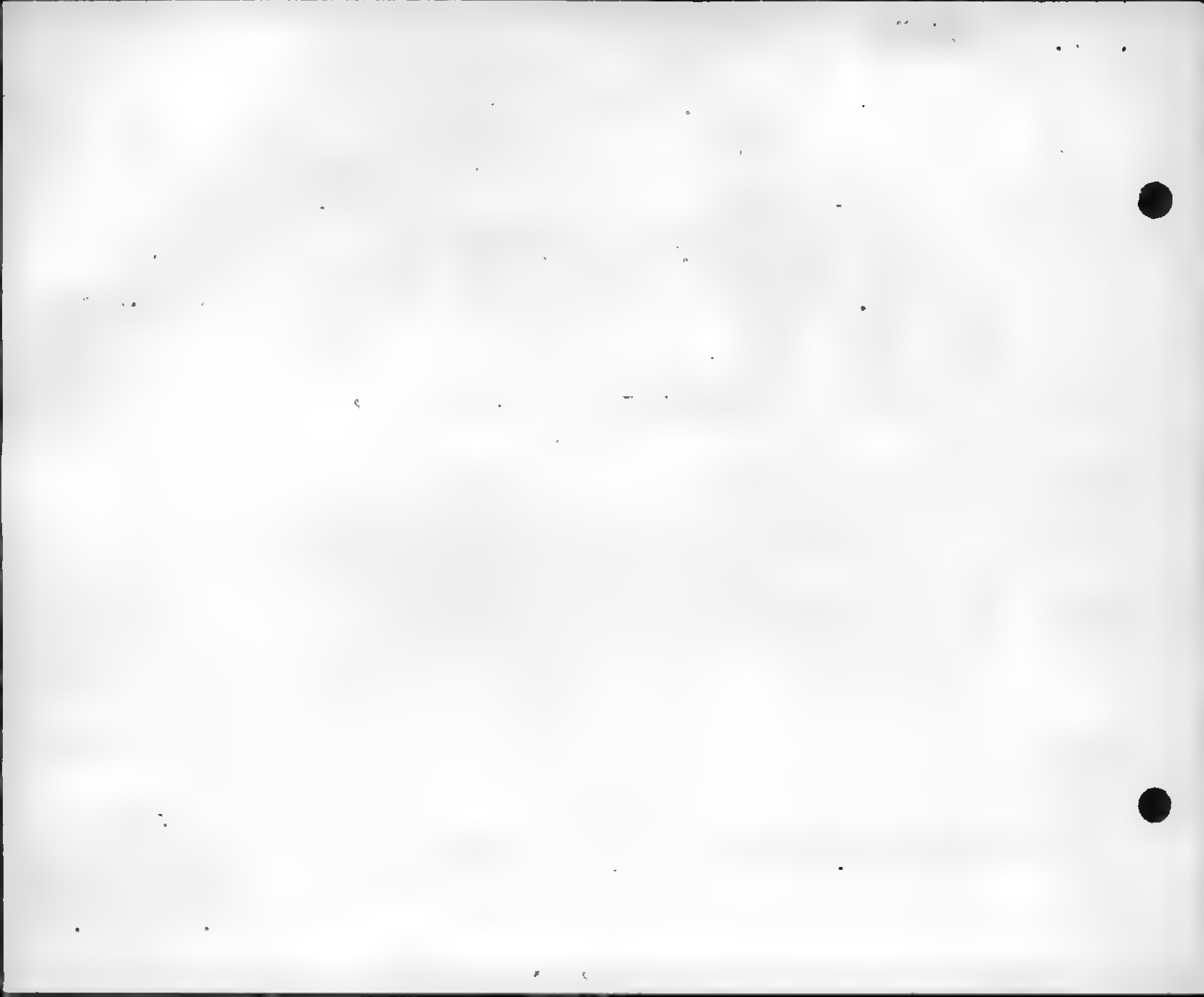
06570

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06568

1 DECEASED-NAME (Type or print) JOHN M. LEE			2a DATE OF DEATH 5 Month 1 Day 69 Year			2b HOUR 7:30 M				
3 SEX M.		4 RACE CAU		5 DATE OF BIRTH 15 June 1910		6 AGE (In years last birthday) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md.				
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER			12a US. AL. OCCUPATION (Kind of work done during most of work no life, even if retired) Service Station Owner			12b KIND OF BUSINESS OR INDUSTRY		
13a US. AL. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY A A		13c CITY OR TOWN Glen Burnie		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 413 B. & A. Blvd., Marley	
14 FATHER'S NAME First Middle Last John Thomas Lee			15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Briscoe							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no			16b SOCIAL SECURITY NO 217-01-2391		17 INFORMANT Address Maynard B. Lee, same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA, ORAL CAVITY 1459 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNK										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State						
22a I certify that (I) (the hospital) attended the deceased from 4-26 , 19 69 , to 5-1 , 19 69 , that (I) (we) last saw the deceased alive on 4-30 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (and) (did not) view the body after death.										
22b SIGNATURE J. L. WOMACK DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c DATE SIGNED 5-3-69				
22d PHYSICIAN'S NAME (Type) DR. J. L. WOMACK M.D.						22e ADDRESS 6701 N. CHARLES ST. BALTO. MD 21204				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		5 May 69		Chester Cemetery		Chestertown, Kent, Md.				
24 FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md.				25a REC'D BY REGISTRAR MAY 6 1969		25b REGISTRAR'S SIGNATURE Charles J. [Signature]				



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06571

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06569

1. DECEASED-NAME (Type or print) Lillian			First Middle Last Lee			2a. DATE OF DEATH Month Day Year May 30, 1969			2b. HOUR 9:20 AM		
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH March 17, 1902			6. AGE (In years last birthday) 67 YRS		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph			12a. USAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			13e. STREET AND NUMBER 213 Douglas Ct. 21231					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage 431.9 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that he (this hospital) attended the deceased from May 28 , 19 69 , to May 30 , 19 69 , that he (we) last saw the deceased alive on May 30 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above by (we) (did) (did not) view the body after death.											
22b. SIGNATURE Teodulo Paglinauan, M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED May 30, 1969		
22d. PHYSICIAN'S NAME (Type) Teodulo Paglinauan, M.D.						22e. ADDRESS 7620 York Road Baltimore, Md 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 6-3-69			23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem			23d. LOCATION (City or Town) (County) (State) BRONCK Co Md.		
24. FUNERAL DIRECTOR E.O. Wilson						ADDRESS 1000 BRAWLEY AVE			25a. REC'D BY REGISTRAR JUN 5 1969		
						25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
GEORGE		NMN	LEMAIRE		5	Month 25 Day 69 Year	3:30 ^a PM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN
MALE	CAUCASIAN		9/13/1878		90			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY	
France	USA				BALTIMORE		Self emp.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUA. OCCUPATION (Kind of work done during most of working life. Even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
TOWSON		GREATER BALTO. MED. CENTER		Grocery Owner Oper.				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
ILL.				Danville				281 S. Virginia Street
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO.		17 INFORMANT Address
George		Laurence		no		none		Family records
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE								
4319 DUE TO, OR AS A CONSEQUENCE OF								
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)								
(b) CEREBRAL HEMORRHAGE								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/21, 19 69, to 5/25, 19 69, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/25/ 19 69, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) (aid) (aid not) view the body after death.								
22b. SIGNATURE Chang Lin, M.D.				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/25/69		
22d. PHYSICIAN'S NAME (Type) CHANG LIN, M.D.				22e. ADDRESS 6701 N. CHARLES ST. BALTO. MD.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial transit		5/26/69		St. Patrick's Cemetery		Danville, Illinois		
24 FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland				25a. REC'D BY REGISTRAR DATE MAY 29 1969		25b. REGISTRAR'S SIGNATURE		



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MD. STATE DEPARTMENT OF HEALTH

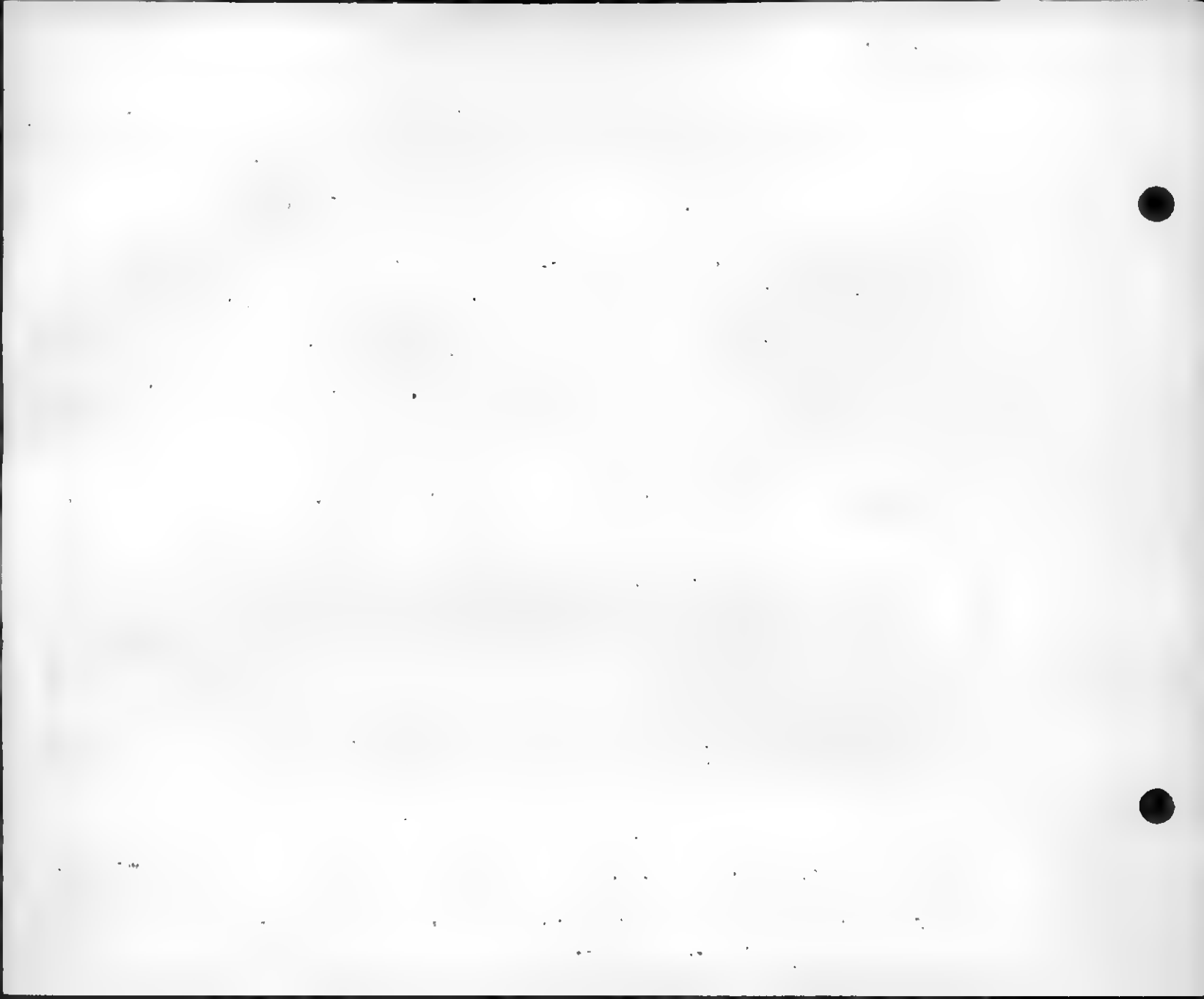
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06573

CERTIFICATE OF DEATH

06571

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b. HOUR	
Mary					Lettieri	5 4 69			4:45A M	
3 SEX	4. RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female	Cau		7/22/02			66 YRS.				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Italy	USA					Baltimore Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Catonsville			6257 Gilston Park Rd			Housewife			Own Home	
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Md			Balt		Catonsville			Same as #11		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			Address				
First Middle Last			First Middle Last							
Louis LeRicci			Assunta Negri							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT			Address		
No			212-10-5627		Mr Gennaro Lettieri			Same as #11		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion,</u>										Sudden
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>Arteriosclerotic Heart Disease</u>										4 yrs.
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Diabetes Mellitus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 19 <u>54</u> to <u>May</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Leo J. Gaver</u> DEGREE <u>M.D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										
22c. DATE SIGNED <u>4/5/69</u>										
22d. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver M.D.</u> 22e. ADDRESS <u>1 Mallow Hill Rd Baltimore, Md. 21228</u>										
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Entombment		5/7/69		Lorraine Mausoleum		Woodlawn, Balt. Co. Md				
24. FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks West Inc				6212 Balt Nat'l Pike Balt Md 21228		DATE <u>MAY 7 1969</u>		<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Mary		Winifred		Long				Month May 21		Day 1969	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7. MONTH, YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White		June 26, 1905		63 YRS				1:25p.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		USA				Baltimore				Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Towson		St. Joseph		Homemaker							
13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. since before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Baltimore		ESSEX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		704A Bauernschmidt Dr. #21			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
THOMAS E. MYERS								EDITH SHIPLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address					
NO		217-01-3090		JAMES A. LONG		ADORE					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Chronic Pleurisy with Effusion											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (he) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>69</u> , to <u>5-21</u> , 19 <u>69</u> , that (he) (we) last saw the deceased alive on <u>5-21</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		Gualberto Gokim, M.D. - DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED May 21, 1969			
22d. PHYSICIAN'S NAME (Type)		Gualberto Gokim, M.D.				22e. ADDRESS 7620 York Road Baltimore, Md. 21204					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		5/24/69		DAK LAWN		BALTO.		MD.			
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J.G. CORNELLY SONS		300 MACE				MAY 26 1969		Gualberto Gokim			



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06573		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06573	
1. DECEASED-NAME (Type or print)		First WALTER	Middle LEE	Last LONG	2a. DATE OF DEATH Month 5 Day 15 Year 69		2b. HOUR 12:55AM
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 5/16/18			6 AGE (In years last birthday) 50 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
10 CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 41 W. Hickman Street		
14. FATHER'S NAME First Middle Last JOHN LONG		15. MOTHER'S MAIDEN NAME First Middle Last CATHERINE GUMP					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and dates of service) YES WW II		16b. SOCIAL SECURITY NO 236 12 81 29		17 INFORMANT CLIN. RECORDS, VA HOSP. FT HOWARD, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 571.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CIRRHOSIS OF LIVER DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5/9/69, 19 to 5/15/69, 19, that (we) last saw the deceased alive on 5/15/69, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death							
22b. SIGNATURE J. D. Talbert, MD DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 5/15/69	
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/19/69		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) ESSEX, MARYLAND	
24. FUNERAL DIRECTOR John J. Connelly Sons		ADDRESS CONNELLY FUNERAL HOME		25a. REC'D BY REGISTRAR MAY 19 1969		25b. REGISTRAR'S SIGNATURE John J. Connelly	



342X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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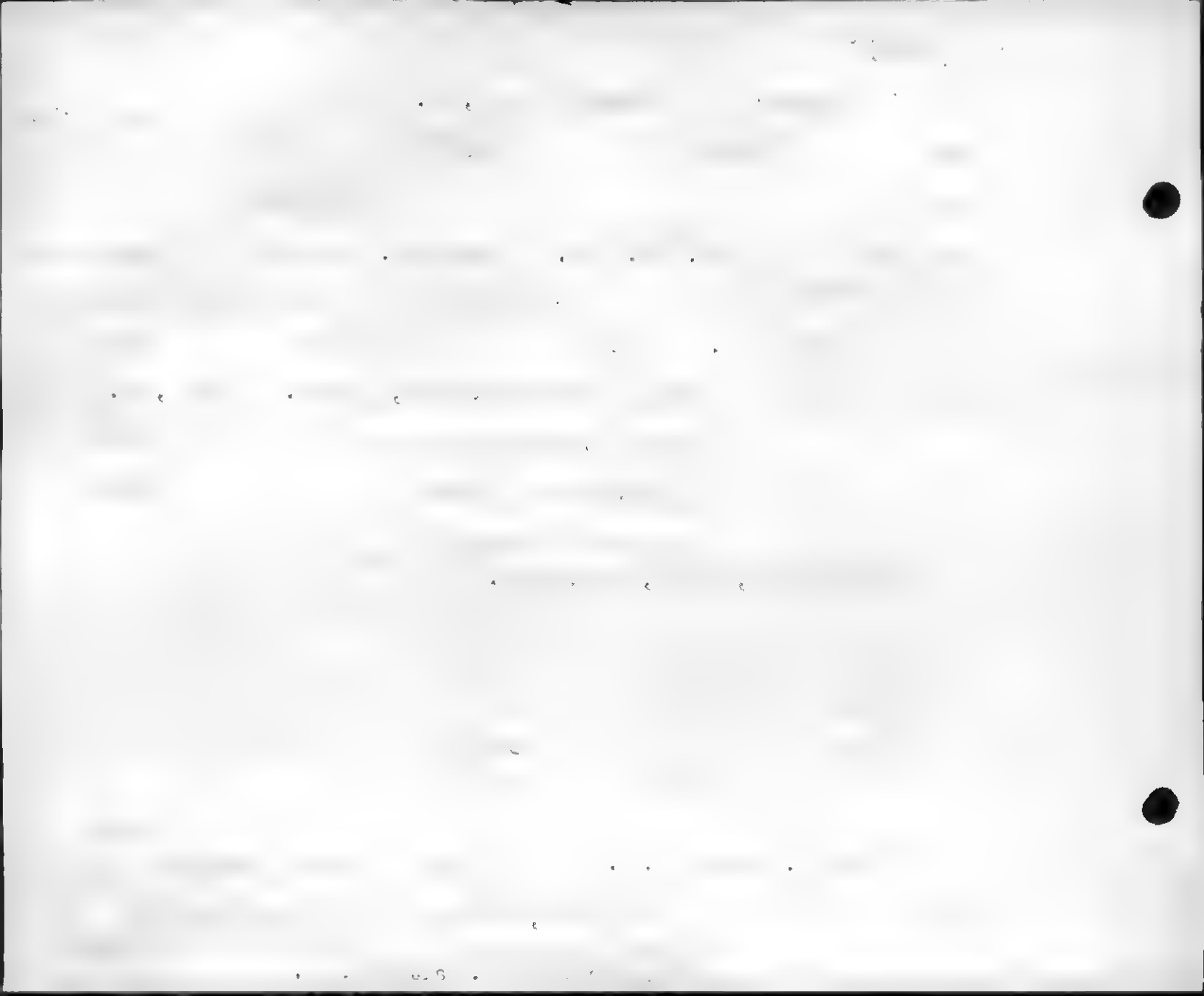
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06576		CERTIFICATE OF DEATH						06574			
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
James Sanchez Lopez						May 29, 1969			p. 1:55 M		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years most birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		9/28/00			88 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Spain		U.S. A.					Baltimore County				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR OCCUPATION		
Catonsville			Spring Grove State Hosp.			Sheet metal worker			Metal Co.		
13a U.S.A. RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b CITY OR TOWN			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER			
Maryland			Prince George Greenbelt					34 H Ridge Road			
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Antonio S. Lopez			Clemorsa Sanchez								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (No, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
No			234-12-8920			Records--Spring Grove State Hospital					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebral infarction.</i>											
342X DUE TO, OR AS A CONSEQUENCE OF <i>Chronic Arteriosclerosis of Arteries</i>											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause <i>Hypertension</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic Arteriosclerosis of Arteries</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (X) (this hospital) attended the deceased from 11/12/62, 19 to May 29, 1969, that (H) (we) last saw the deceased alive on May 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death											
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED		
Rafael H. Marin, M.D.									5-29-69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
			Spring Grove State Hospital								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			6/2/69			Gate of Heaven			Silver Spring Montg. Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Francis Gasch's Sons			Hyattsville, Md.			JUN 4 1969			[Signature]		



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MIDDLE															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First BERNARD		Middle EUGENE		Last LYNCH, SR.		2a. DATE OF DEATH Month 5/ Day 1/ Year 69 2b. HOUR 11:30P M						
3 SEX MALE			4 RACE WHITE		5. DATE OF BIRTH 4/12/95			6. AGE (In years last birthday) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			Md					
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not a hosp for long term care, give street address) VET. ADM. HOSP. FT HOWARD, MD. CAMPBELL			12a. USUAL OCCUPATION (Kind of work done during most of year prior to death, or if retired) CONSTRUCTION			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5048 Chalgrove Avenue						
14 FATHER'S NAME First JAMES			Middle E.		Last LYNCH		15. MOTHER'S MAIDEN NAME First GERTRUDE			Middle CLEFT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown YES			(If yes give war or dates of service) WW I		16b. SOCIAL SECURITY NO. 218 10 68 62		17. INFORMANT Address CLIN. RECORDS, VA HOSP. FT HOWARD, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA										RECENT					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PULMONARY HEART DISEASE										OLD					
(c) PULMONARY EMPHYSEMA															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, MARKED, GENERALIZED.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (this hospital) attended the deceased from 3/19/69 , 19____, to 5/1/69 , 19____, that (I) (we) last saw the deceased alive on 5/1/69 , 19____, and that (I) (we) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.															
22b. SIGNATURE John D. Talbert, M.D.										DEGREE MD		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/2/69	
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.										22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REBURN (Specify) BURIAL			23b. DATE 5/5/69		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE, NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND							
24. FUNERAL DIRECTOR WITZKE FUNERAL HOME 4101 Edmondson Ave. Baltimore, Md.															
25. DIED BY REGISTERED MAY 6 1969															
26. PREPARATION SIGNATURE Charles J. J...															



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VR 41
45M

<div style="text-align: center;"> <p>06578</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> <p style="text-align: right;">06576</p> </div>									
1 DECEASED-NAME (Type or print)			First Middle Last JOHN EDWIN LYNCH			2a. DATE OF DEATH Month Day Year 5 14 69			2b. HOUR 4:40 ^P
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH 8-11-91		6 AGE (In years lost birthday) 77 XX YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			Md
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED. CENTR			2a. USLA. OCCUPATION (Kind of work done during most of working life, even if retired) Capt. Fire Department			12b. KIND OF BUSINESS OR INDUSTRY Fireman	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1705 Edgewood Road	
14 FATHER'S NAME First Middle Last William Lynch			15. MOTHER'S MAIDEN NAME First Middle Last Sara Grace						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 558-66-525-J1		17. INFORMANT Elizabeth Lynch		Address 1705 Edgewood Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK 1109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ARTEROSCLEROTIC HEART DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH APPROX 30* 24 hrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ATRAL FIBRILLATION -HEART FAILURE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State 4AM 4:40PM					
22a. I certify that (I) (this hospital) attended the deceased from 5-14 , 19 69 , to 5-14 , 19 69 , that (I) (we) last saw the deceased alive on 5-14 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, that we did (did not) view the body after death.									
22b. SIGNATURE Duncan McGhie		22c. DATE SIGNED 5/14/69		22d. ADDRESS GREATER BALTIMORE MEDICAL CENTRE		22e. ADDRESS GREATER BALTIMORE MEDICAL CENTRE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-16-69		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore County Maryland			
24. FUNERAL DIRECTOR William E. Johnson		25a. RECEIVED BY REGISTRAR MAY 19 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION



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06579

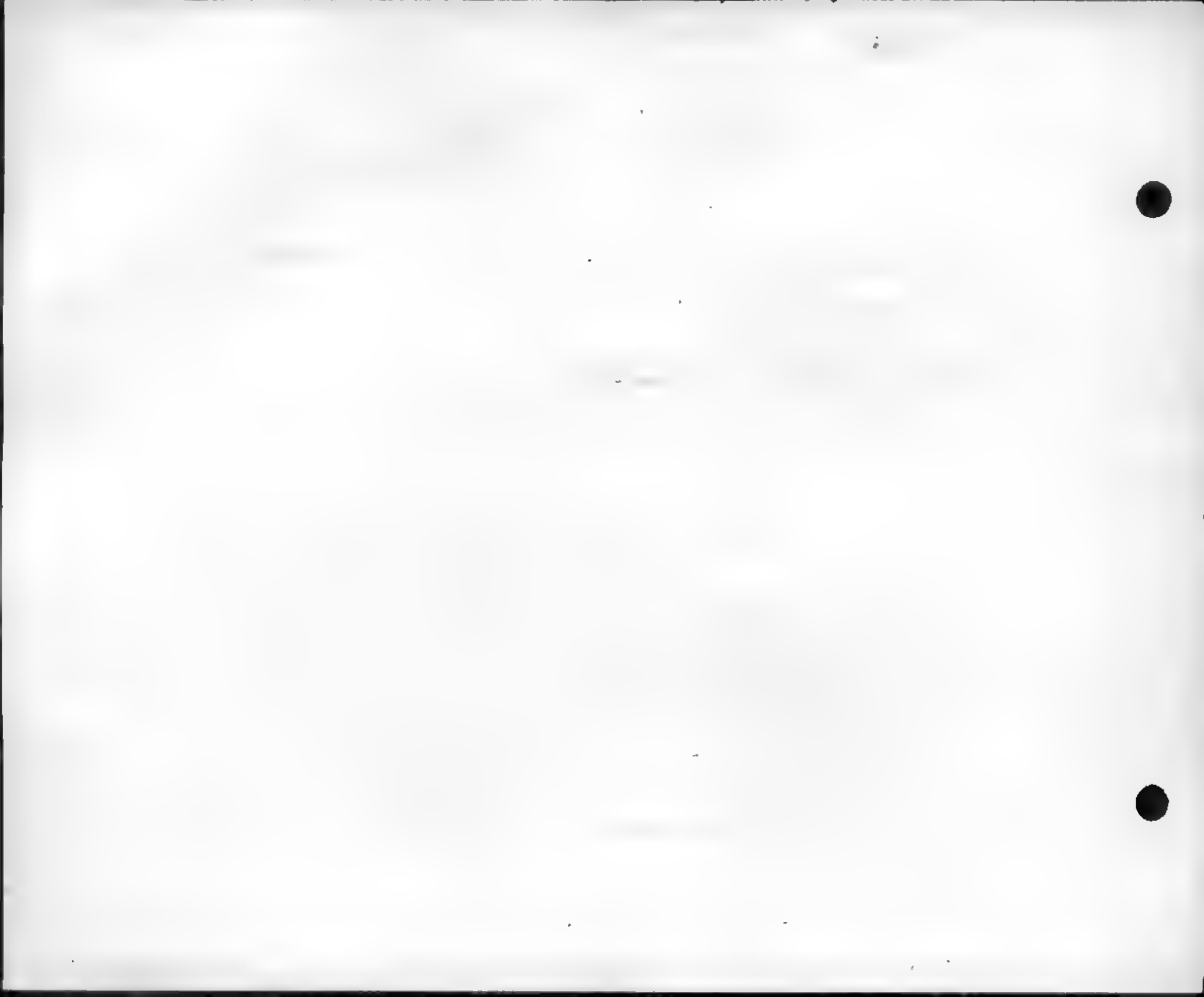
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06577

1. DECEASED-NAME (Type or print) First Middle Last Wilhelmina A. Mangold			2a. DATE OF DEATH Month Day Year 5 25 1969		2b. HOUR 2.55 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 25, 1882		6. AGE (In years last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Germany	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Balto. Co.		12b. KIND OF BUSINESS OR INDUSTRY Md
10. CITY OR TOWN OF DEATH Towson, Md.		11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) Dulaney-Towson Nursing Home		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if in hospital or residence before admission) Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Lutherville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 111 Martingale, Rd.
14. FATHER'S NAME First Middle Last Karl Gruneberg			15. MOTHER'S MAIDEN NAME First Middle Last Caroline Macherott		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) [If yes give war or dates of service] No		16b. SOCIAL SECURITY NO. 216-46-6273		17. INFORMANT Address Dulaney-Towson Nursing Home 111 West Rd, 04	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 9, 1967</u> , to <u>5/25/1969</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>5/19/69</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.					
22b. SIGNATURE <u>M. X. Quinn</u>		DEGREE ATTENDING PHYS.		22c. DATE SIGNED <u>5/27/69</u>	
22d. PHYSICIAN'S NAME (Type) Dr. Kevin Quinn		22e. ADDRESS 1927 York Rd. 21204-21093			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-28-69		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR ADDRESS John C. Miller Inc-6415 Belair Road-21206			
25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>			

VR A15 45M 189

4124



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06580		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06578	
Item 10 Film 412		5/22/69 kk		CERTIFICATE OF DEATH	
1. DECEASED NAME (Type or print) PHILIP F MANSER			2a. DATE OF DEATH May 7, 1969		2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH Nov. 15, 1916		6. AGE (In years last birthday) 52 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		12b. KIND OF BUSINESS OR INDUSTRY
10. CITY OR TOWN OF DEATH Baltimore 21234		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2905 Erie Ave. Clerk		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2905 Erie Avenue
14. FATHER'S NAME First Middle Last Philip Manser			15. MOTHER'S MAIDEN NAME First Middle Last Annie C. Bracken		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) yes WWII		16b. SOCIAL SECURITY NO. 217 03 3268	17. INFORMANT Address family records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the spine - metastatic 1102 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mo.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 69 , to May 7 , 19 69 , that (I) (we) lost saw the deceased alive on May 5 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Geo H. Beck		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/9/69	
22d. PHYSICIAN'S NAME (Type) George H. Beck		22e. ADDRESS 6012 Harford Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE May 12, 1969		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION (City or Town) (County) (State) Parkville, Balto County					
24. FUNERAL DIRECTOR C. F. EVANS & SON 8802 Harford Road		25a. REC'D BY REGISTRAR MAY 13 1969		25b. REGISTRAR'S SIGNATURE William L. Sander	



06581

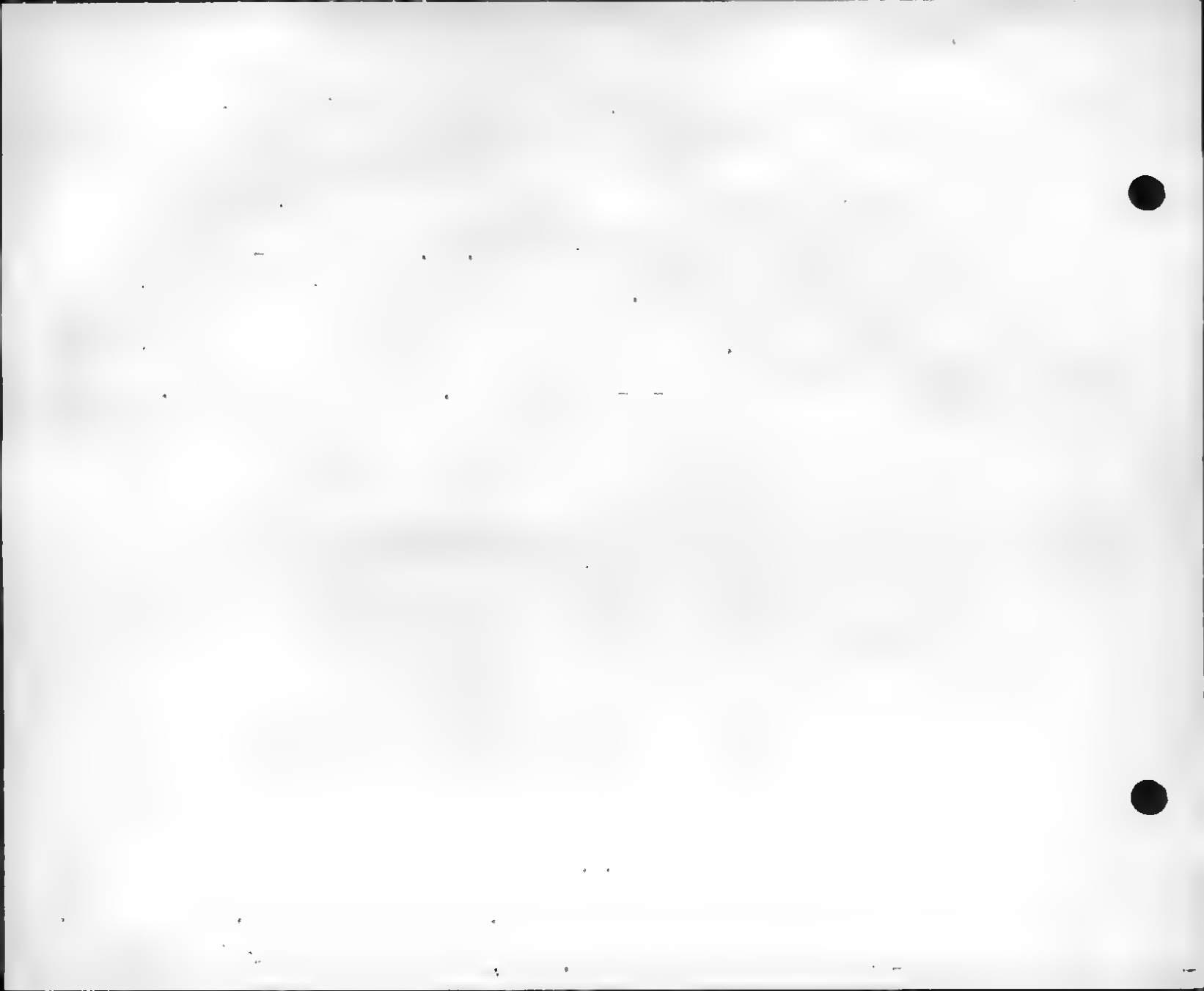
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06579

1. DECEASED-NAME (Type or print) Helen		First Tyler		Middle MARCY		Last		2a. DATE OF DEATH Month 5 Day 21 Year 1969		2b. HOUR 11:30 AM	
3. SEX female		4. RACE white		5. DATE OF BIRTH Feb. 19, 1893		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS 76 DAYS 76		IF UNDER 24 HRS. HOURS 76 MIN 76	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor Nurs. Hm.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary - retired		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6701 Maxalea Drive			
14. FATHER'S NAME First Walter		Middle B.		Last Tyler		15. MOTHER'S MAIDEN NAME First Ida		Middle Ferguson		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-32-8395		17. INFORMANT Henry C. Marcy		Address 6701 Maxalea Dr. Balto. 12			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Apoplexy Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last Arteriosclerosis (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 6 months 15 yrs										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCAT ON Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from July 19 50 to 21 May 19 69 , that (I) last saw the deceased alive on 21 May 19 69 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles H. Reier		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 22 May 69					
22d. PHYSICIAN'S NAME (Type) CHARLES H. REIER, M.D.		22e. ADDRESS 6701 YORK ROAD									
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE 5/22/69		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		23d. LOCATION (City or Town) Balto.		(County)		(State) Md.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd. Balto. 12		25a. REC'D BY REGISTRAR DATE MAY 28 1969		25b. REGISTRAR'S SIGNATURE Charles J. ...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



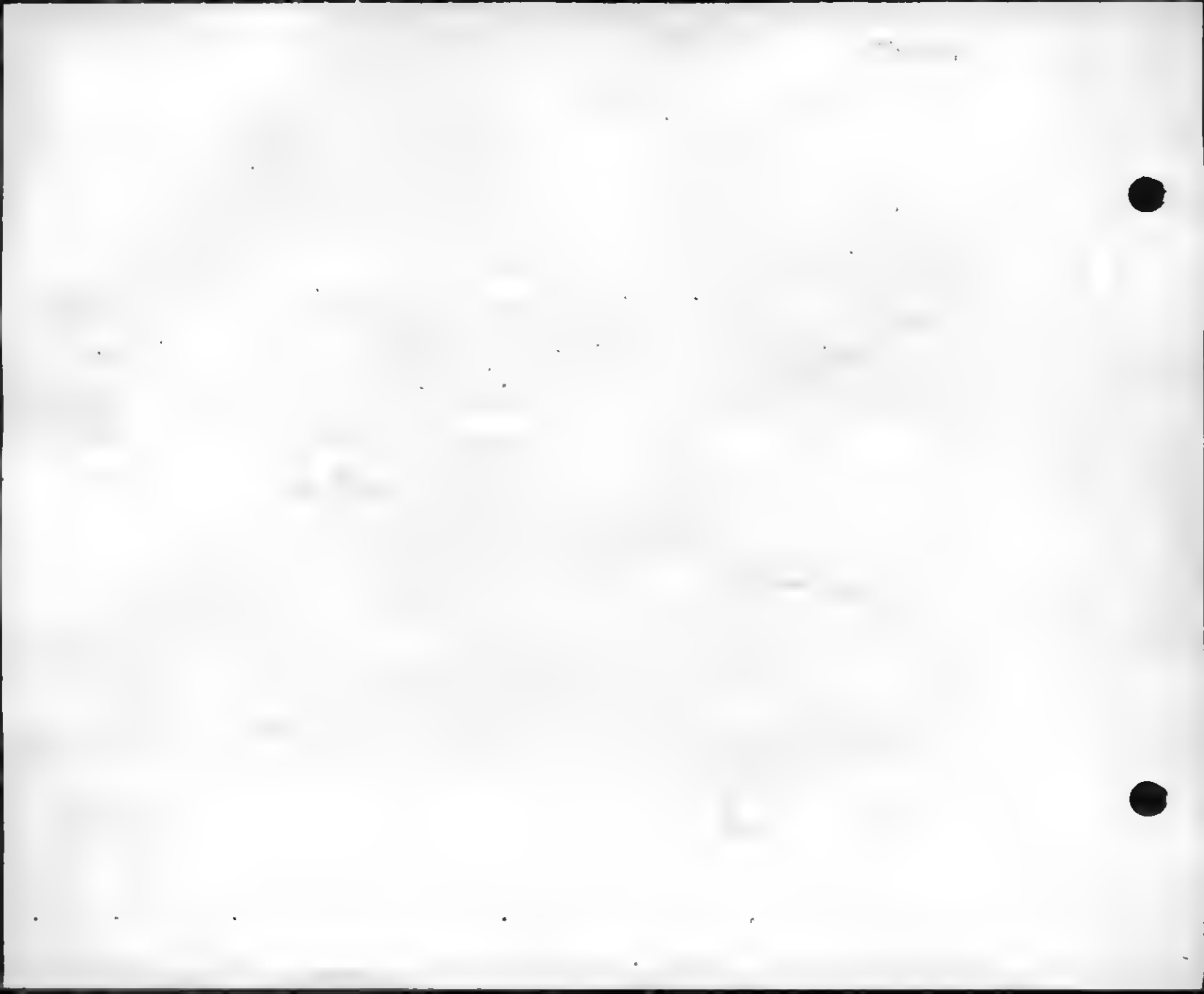
4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06580											
06582						CERTIFICATE OF DEATH					
1. DECEASED NAME (Type or print) First Middle Last Mary Josephine Martz						2a. DATE OF DEATH 5 Month 16 Day 69 Year				2b. HOUR 12:35 PM	
3. SEX F		4. RACE W		5. DATE OF BIRTH 5-3-96		6. AGE (n years lost birthday) 73 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Penna		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto Co. Gen			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) H.W.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD			13b. COUNTY Balto		13c. CITY OR TOWN RANDALLSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3917 Rayton Rd		
14. FATHER'S NAME First Middle Last Jacob Oseta				15. MOTHER'S MAIDEN NAME First Middle Last Carolyn McDowell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)				16b. SOCIAL SECURITY NO NONE		17. INFORMANT Chart			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCD, chronic heart failure DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hr. 1 mo.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5/14 , 19 67 , to 5/16 , 19 67 , that (I) <input checked="" type="checkbox"/> view post mortem the deceased alive on 5/16 , 19 67 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE Lawrence Solomon MD						22c. DATE SIGNED 5/16/69					
22d. PHYSICIAN'S NAME (Type) LAWRENCE SOLOMON						22e. ADDRESS 3600 LOCKHART DR.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE May 19, 69		23c. NAME OF CEMETERY OR CREMATORY Bellwood Cem.		23d. LOCATION (City or Town) (County) (State) Bellwood Pa. Blair Co. Penna.					
24. FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown						25a. REC'D BY REGISTRAR DATE MAY 19 1969		25b. REGISTRAR'S SIGNATURE James Judge			

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 2&13 File 4113

6/6/69 JK

06583

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06581

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			Month	Day	Year	2b HOUR		
SUEN				TING	MAU	MAY 23 1969			May	23	1969	M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			Month	Day	Year	
Male	Chinese	1-10-38	37	MONTHS		DAYS		May			23	1969	Unk.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED			9 COUNTY OF DEATH			2d HOUR		
CHINA			CHINA			NEVER MARRIED			Baltimore			Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Sparrows Point			Beth. Steel Co.			CHIEF BOOK			STEAMER					
13a USUAL RESIDENCE (Where deceased lived, if institution Res. since before admission)			13b CITY OR TOWN			13c INSIDE CITY LIMITS?			13d STREET AND NUMBER					
STATE Maryland			HONG KONG			YES			Unk. 1207 Metropole Bldg.					
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO			17 INFORMANT		
?			?			NO			-			ROBT. C. HERR		
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			18b CAUSE OF DEATH			18c CAUSE OF DEATH			18d CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF					
Drowning			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?					
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES			NO		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
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OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town	County	State
OR CONTRIBUTING			Unk. 4-23-1969			Drowning			Sparrows Point-Balto.			M.D.		
21a EXTERNAL CAUSE WAS PRIMARY			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			21d LOCATION Street or R.F.D. No			City or Town		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

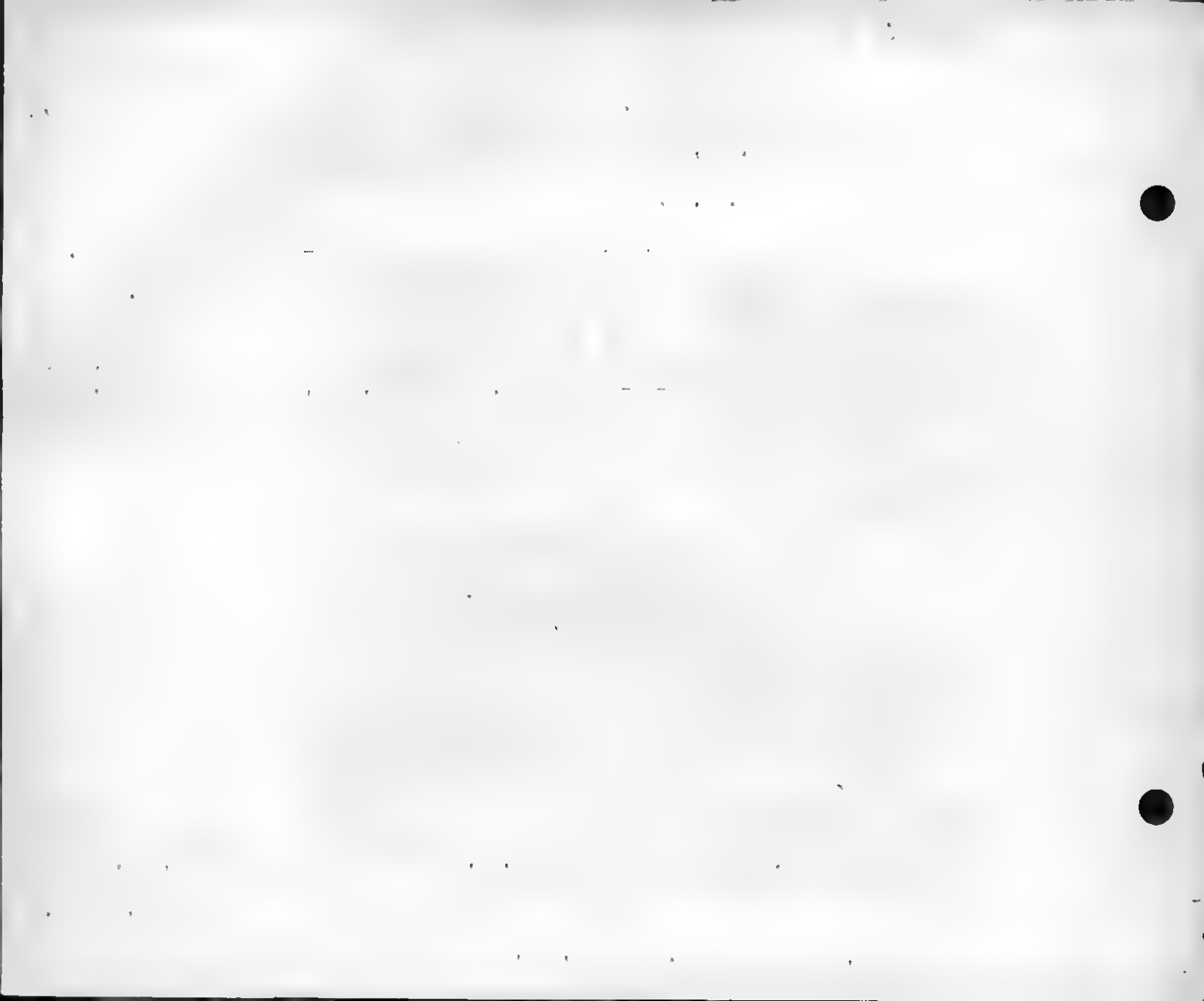
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06584

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06582

1 DECEASED NAME (Type or Print) First Thomas Middle A. Last May			2a DATE KNOWN OF DEATH Month 5 Day 70 Year 69			2b HOUR 7:15 PM			
3 SEX Male	4 RACE White	5 DATE OF BIRTH Oct. 14, 1891	6 AGE (In years last birthday) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month May Day 10 Year 1969			2d HOUR 8:15 PM
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md			
10 CITY OR TOWN OF DEATH Edgemere			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7318 Waldman Avenue			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Bethlehem Steel Co.			12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore	13c CITY OR TOWN Edgemere		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 7318 Waldman Ave.	
14 FATHER'S NAME First Abner Middle May Last May			15 MOTHER'S MAIDEN NAME First Annie Middle Laura Last Laura						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO (If yes give war or dates of service) 213-07-9685		17 INFORMANT (Wife) Mrs. Rebecca A. May, 7318 Waldman Ave.				
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Melvin B. Davis</u>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 5/12/69	
EXAMINER'S NAME (Type) Melvin B. Davis			M. D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		6800 Mornington Road	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 5/14/69		23c NAME OF CEMETERY OR CREMATORY Red Mount Cemetery		23d LOCATION (City or Town) (County) (State) Warren Co. Penna.		
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						25a REC'D BY REGISTRAR DATE MAY 14 1969		25b REGISTRAR'S SIGNATURE <u>James J. Judge</u>	

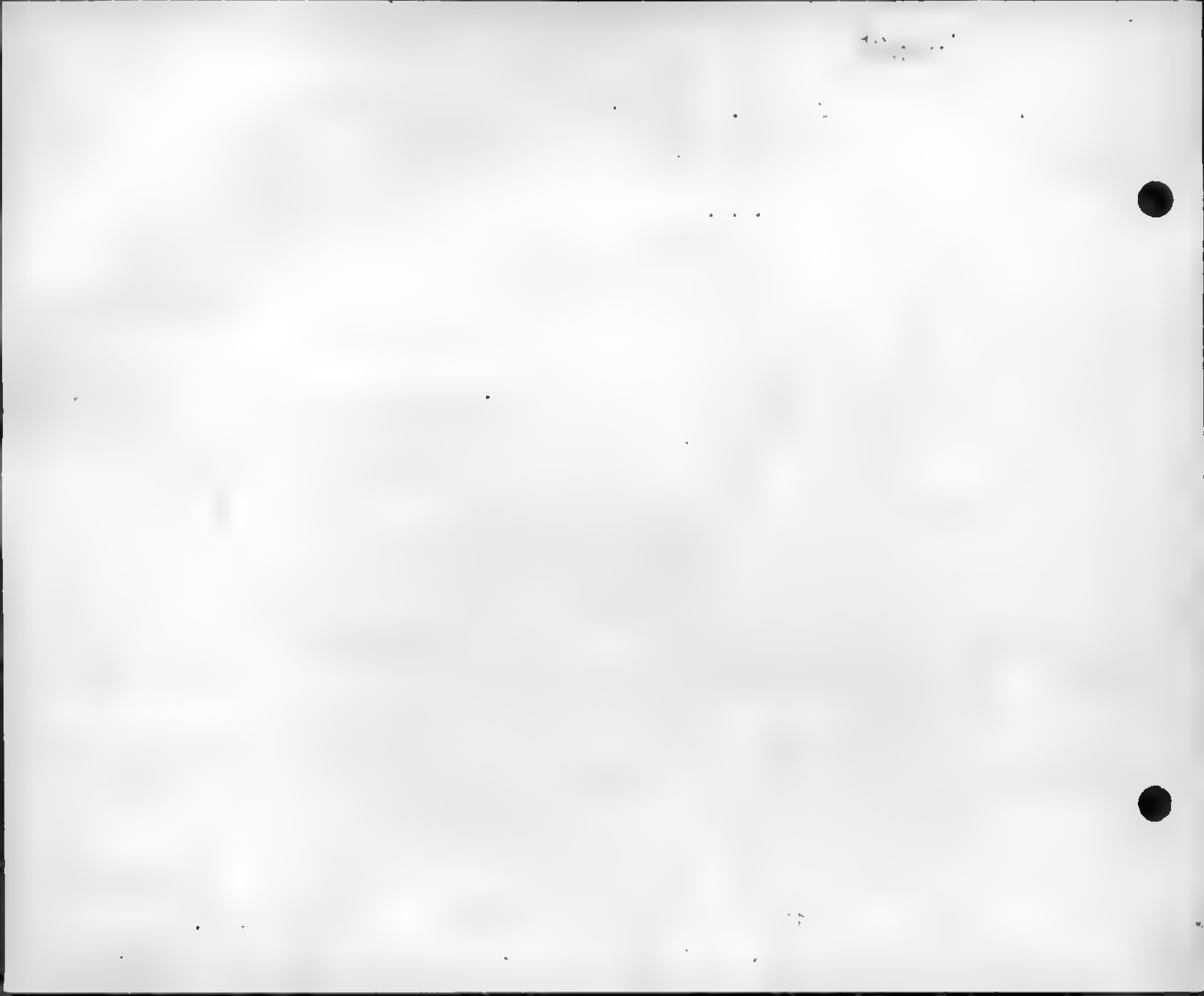


1
7/12/4

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAY 1969										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06583																																							
1 DECEASED NAME (Type or print)										2a DATE OF DEATH										2b HOUR																																							
Lydia E. McCleary										May 12 1969										M																																							
3 SEX Female										4 RACE white										5 DATE OF BIRTH 9/3/84										6 AGE (In years last birthday) 84 YRS.										7 IF UNDER 1 YEAR MONTHS DAYS										8 IF UNDER 24 HRS HOURS MIN									
7a BIRTHPLACE (State or foreign country) Maryland										7b CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md																													
10 CITY OR TOWN OF DEATH Catonsville										11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Summit Nursing Home										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																													
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md										13b COUNTY Balto										13c CITY OR TOWN Balto										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 5114 Edmondson Avenue																			
14 FATHER'S NAME First Middle Last Jacob Karcher										15 MOTHER'S MAIDEN NAME First Middle Last Catherine Schmidt										16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)										16b SOCIAL SECURITY NO.										17 INFORMANT Mrs. Hugh Ellison, 6108 Deerbrook Road, 21228 Address																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC DISEASE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS+																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) DUE TO, OR AS A CONSEQUENCE OF										(c) DUE TO, OR AS A CONSEQUENCE OF																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.										21f LOCATION Street or R.F.D. No. City or Town County State																																							
22a I certify that (I) (this hospital) attended the deceased from JAN, 1954, to 5/12, 1969, that (I) (we) last saw the deceased alive on 5/11/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b SIGNATURE Thomas E. Ruach MD										DEGREE ATTENDING PHYSICIAN MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c DATE SIGNED 5/13/69																																							
22d PHYSICIAN'S NAME (Type) Thomas E. Ruach MD										22e ADDRESS 5550 Balto Natl Pk																																																	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial										23b DATE 5/15/69										23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery										23d LOCATION (City or Town) (County) (State) Baltimore, Md.																													
24 FUNERAL DIRECTOR Witzke Funeral Dir. 4101 Edmondson Ave.										ADDRESS										25a. REC'D BY REGISTRAR MAY 14 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 5 45M

06586										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06584																													
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
FRANCIS NICHOLS McDONALD										Month MAY Day 2, Year 1969										11:55 PM																													
3. SEX MALE										4. RACE CAUCASIAN										5. DATE OF BIRTH JULY 21, 1906										6. AGE (In years last birthday) 62 YRS																			
7a. BIRTHPLACE (State or foreign country) R.I.										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH BALTIMORE Md																			
10. CITY OR TOWN OF DEATH FORT HOWARD										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOSPITAL VETERANS ADMINISTRATION										2c. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PHYSICIAN										12b. KIND OF BUSINESS OR INDUSTRY MEDICINE																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before address) WASHINGTON D.C.										13b. COUNTY										13c. CITY OR TOWN WASHINGTON DC										13d. HOUSE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 2525 36th St S.E.									
14. FATHER'S NAME First MIDDLE Last JEREMIAH McDONALD										15. MOTHER'S MAIDEN NAME First MIDDLE Last CATHERINE NICHOLS										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service) WW II										16b. SOCIAL SECURITY NO 255 07 2106										17. INFORMANT CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA										UNKNOWN																																							
3579 DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) DECUBITUS ULCERS OF LEGS										UNKNOWN																													
DUE TO, OR AS A CONSEQUENCE OF										(c) PERIPHERAL NEUROPATHY										UNKNOWN																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																																																	
HEMIPLEGIA, RIGHT SIDE																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 12/31/68, 19 to 5/2/69, 19, that (X) (we) last saw the deceased alive on 5/2/69, 19, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.																																																	
22b. SIGNATURE G. J. M. Reddy M.D. DEGREE										ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>										22c. DATE SIGNED 5/3/69																													
22d. PHYSICIAN'S NAME (Type) GADDUM J. M. REDDY, M.D.										22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE May 6, 1969										23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CATHOLIC CEMETERY CLINTON										23d. LOCATION (City or Town) (County) (State) MARYLAND																			
24. FUNERAL DIRECTOR James T. Ryan Funeral Home, 317 Penna. Ave. S.E. Wash. ngtn, D.C.										ADDRESS										25a. REC'D BY REGISTRAR MAY 7 1969										25b. REGISTRAR'S SIGNATURE																			

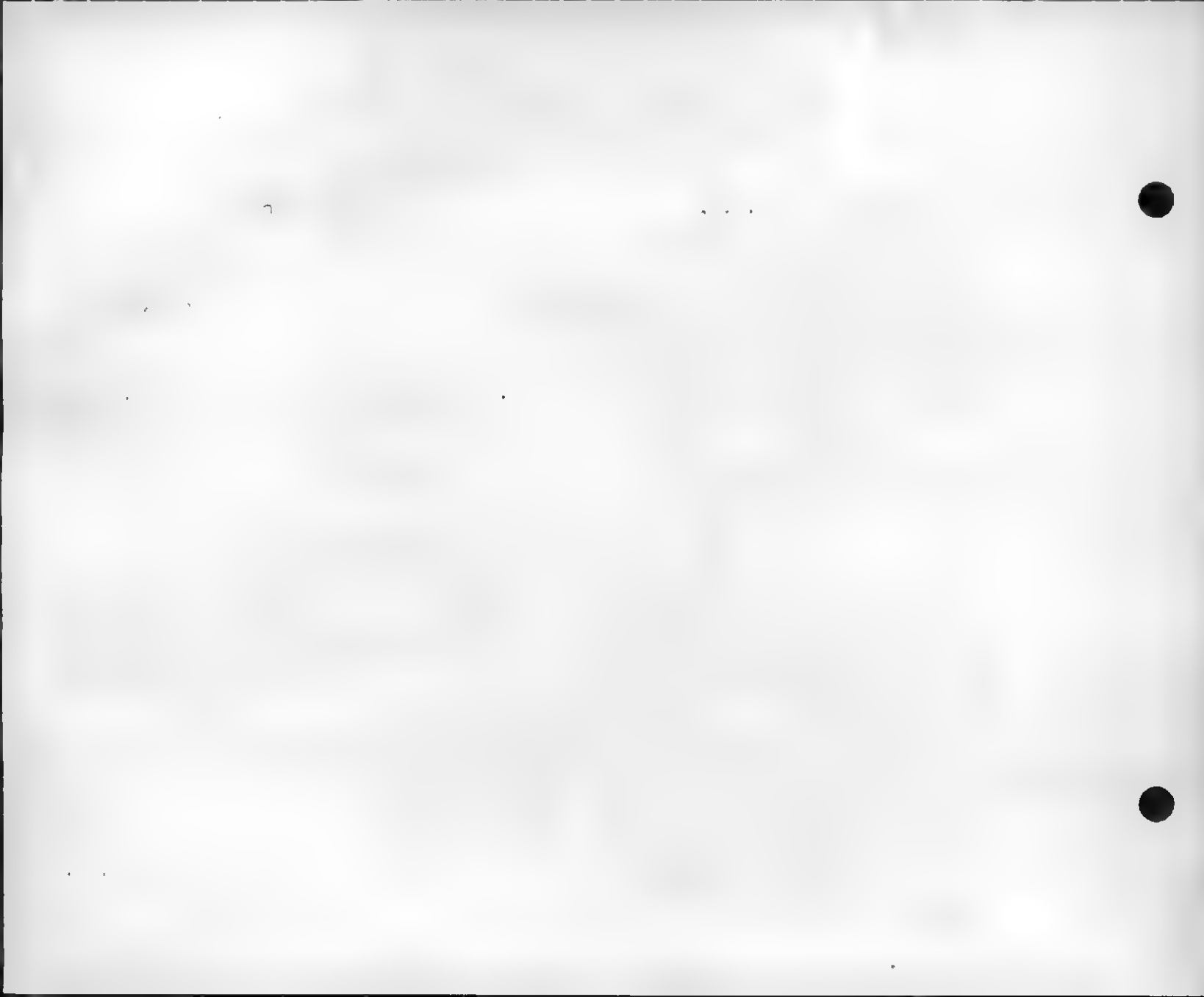
MEDICAL CERTIFICATION

WASH. D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>06587</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div> <div>06585</div>													
1 DECEASED NAME (Type or print)				First Middle Last				2a DATE OF DEATH				2b HOUR	
MARY JANE MCKITRICK								May Month 4, 1969 Year				330 ¹ M	
3 SEX		4 RACE		5. DATE OF BIRTH				6 AGE (In years last birthday)		7c UNDER 1 YEAR		7d UNDER 24 HRS	
Female		White		8-29-1885				83 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md	
Maryland		U.S.A.				Baltimore							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
Catonsville				Ridgeway Manor Nursing Home									
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER					
Maryland				Anne Arundel		YES		421 Greenwood Road					
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last									
Andrew Weatherstine				Ellen Seebode									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)				16b SOC. SEC. NO.		17 INFORMANT Address							
No				212-10-5141		Mrs. Laura Snyder, 421 Greenwood Rd. 21090							
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4-19 DUE TO, OR AS A CONSEQUENCE OF												Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
				19 P.M.									
21a INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>				21b PLACE OF INJURY (At home farm street, factory, office building, etc.)				21c LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (the hospital) attended the deceased from <u>Jan</u> , 19 <u>68</u> , to <u>4 May</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3 May</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED	
<u>William Goodman, MD</u>												5 May 69	
22d PHYSICIAN'S NAME (Type)				22e ADDRESS									
William Goodman				1334 Sulphur Spring Road, Balto. Md.									
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
BURIAL				5-7-1969		Loudon Park Cemetery				Baltimore, Maryland			
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Howard H. Hubbard, 4107 Wilkens Ave. 21229								MAY 6 1969		<u>William Goodman</u>			



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06588										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06586									
1 DECEASED-NAME (Type or print)			First			Middle			Last			2a DATE OF DEATH			2b. HOUR														
ROBERT			J.			McNEIL, JR			Month MAY			Day 10			Year 1969			12:29											
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years lost birthday)			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS DAYS			IF UNDER 24 HRS HOURS			IF UNDER 24 HRS MIN								
MALE			NEGROID			DECEMBER 23, 1928			40 YRS																				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 COUNTY OF DEATH																				
NORTH CAROLINA			U.S.A.						BALTIMORE																				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY																				
FORT HOWARD			VETERANS ADMINISTRATION HOSPITAL			LABORER						CONSTRUCTION																	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER																	
MARYLAND						BALTIMORE						619 NORTH FREMONT AVENUE																	
14 FATHER'S NAME			First			Middle			Last			15 MOTHER'S M.A.DEN NAME			First			Middle			Last								
JAMES			W			McNEIL						DOVE									McLAIM								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address																				
YES			WW II			242 40 2009			CLINICAL RECORDS, VA HOSP, FT HOWARD, MD																				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE																													
450X DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																													
(b) MULTIPLE PULMONARY EMBOLI																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. ALTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f LOCATION Street or R.F.D. No City or Town County State																							
22a. I certify that (X) (this hospital) attended the deceased from 4/22/69, 19__, to 5/10/69, 19__, that (X) (we) last saw the deceased alive on 5/10/69, 19__, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.																													
22b. SIGNATURE Pushpendra Senan																													
22c. DATE SIGNED 5/10/69																													
22d. PHYSICIAN'S NAME (Type) PUSHPENDRA SENAN, M.D.																													
22e ADDRESS VA HOSPITAL, FORT HOWARD, MD																													
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)																				
BURIAL			5-13-69			Baltimore Nat'l Cem.			Baltimore			Maryland																	
24 FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOME, 1701 Laurens, Baltimore, Md																													
25a REC'D BY REG. STR. MAY 12 1969																													
25b REGISTRAR'S SIGNATURE																													

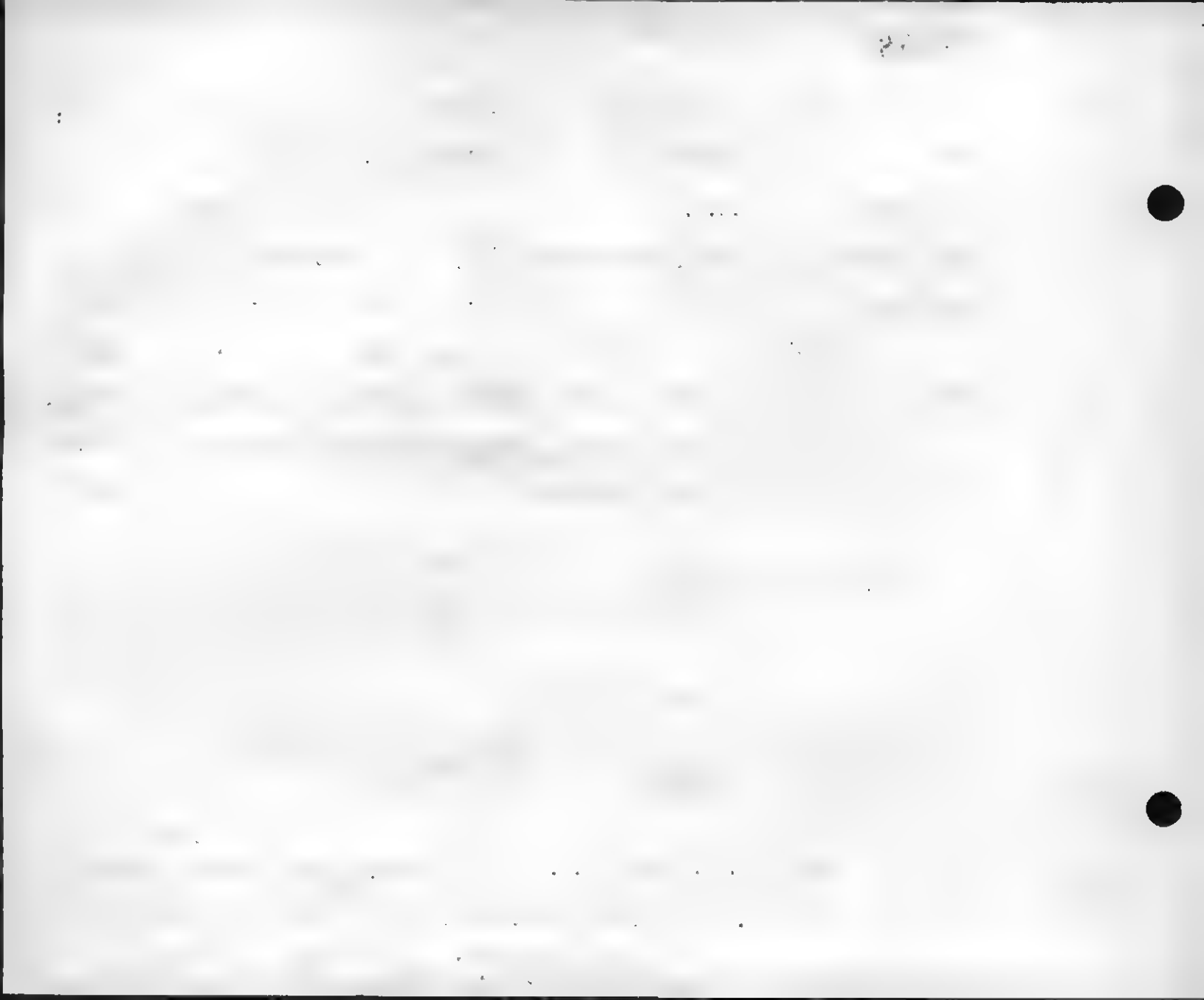
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First ALLEN		Middle DANIEL		Last McPOLAND		2a. DATE OF DEATH Month MAY Day 3 Year 1969		
3 SEX MALE			4 RACE CAUCASIAN		5. DATE OF BIRTH DECEMBER 26, 1896			6 AGE (In years last birthday) 72 YRS		7b. HOUR 6:30 A	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		12b. KIND OF BUSINESS OR INDUSTRY FIREARMS		
10 CITY OR TOWN OF DEATH FORT HOWARD			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) HOSPITAL VETERANS ADMINISTRATION			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MACHINIST			12b. KIND OF BUSINESS OR INDUSTRY FIREARMS		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER WALDORF HOTEL, NORTH AVE & CHARLES ST		
14. FATHER'S NAME First CHARLES Middle L. Last McPOLAND			15. MOTHER'S MAIDEN NAME First IDA Middle M. Last SIMMS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> WW I			16b. SOCIAL SECURITY NO 219 12 6010			17 INFORMANT Address CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LEFT CORONARY THROMBOSIS WITH LEFT MYOCARDIAL INFARCTION										UNKNOWN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										UNKNOWN	
DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROSIS											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) CARCINOMA OF RECTUM											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/26/69 , 19____, to 5/3/69 , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/3/69 , 19____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE <i>G. J. M. Reddy</i>						DEGREE M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/3/69	
22d. PHYSICIAN'S NAME (Type) GADDUM J. M. REDDY, M.D.						22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Type) Burial			23b. DATE 5/6/69.		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24 FUNERAL DIRECTOR RUCK FUNERAL HOME						ADDRESS 5303 Harford Rd. Baltimore, Md.		25a. REC'D BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judy</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

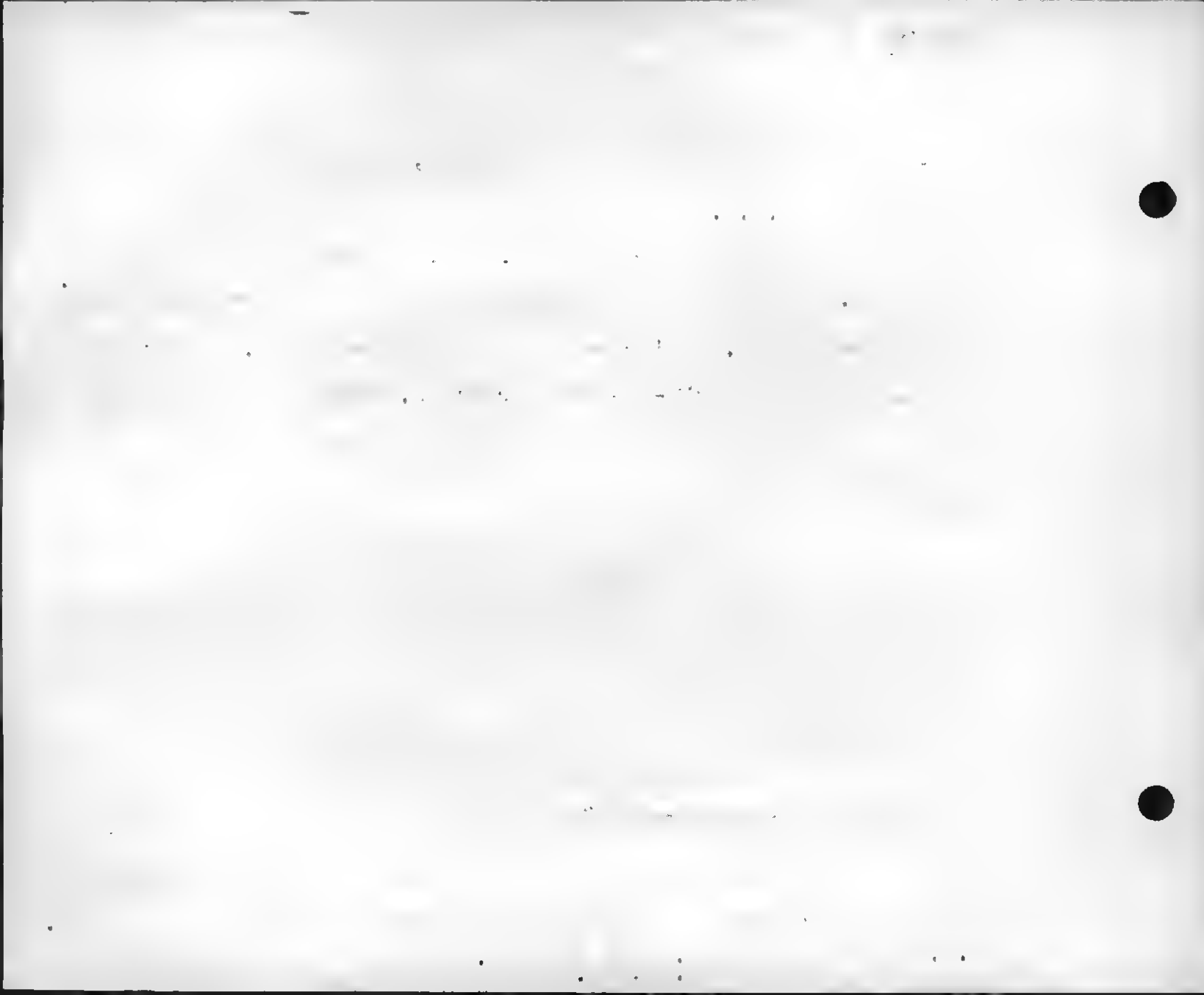
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VA
45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06590		CERTIFICATE OF DEATH						06588		
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR 00	
ELLEN			RUTH			MEEKINS			5 17 69	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		WHITE		June 8, 1898		70 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Virginia		U.S.A.				BALTIMORE Co.		Own Home		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON			GREAT. BALT. MED. CEN.			Homemaker				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Md.			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Apt. 2B	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
David M. O'Brien			Flora E. Perkins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address	
No			219-36-0170			Arthur G. Meekins			(Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Unknown Primary									Appx. 3wks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Old Myocardial Infarction (anterior)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
May 16, '69			Abdominal Mass			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (he) (this hospital) attended the deceased from April 30, 1969, to May 17, 1969, that (he) (we) last saw the deceased alive on May 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED	
Sabanayagam M.D.									5/17/69	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
Dr. P. Sabanayagam M.D.			6701 N. Charles St.			21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Entombment			5/20/69			Greenmount Mausoleum			Baltimore Md.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
H.W. Jenkins & Sons Co.			4905 York Rd. Balto. 12, Md.			MAY 19 1969			Charles Judge	

MEDICAL CERTIFICATION

23a



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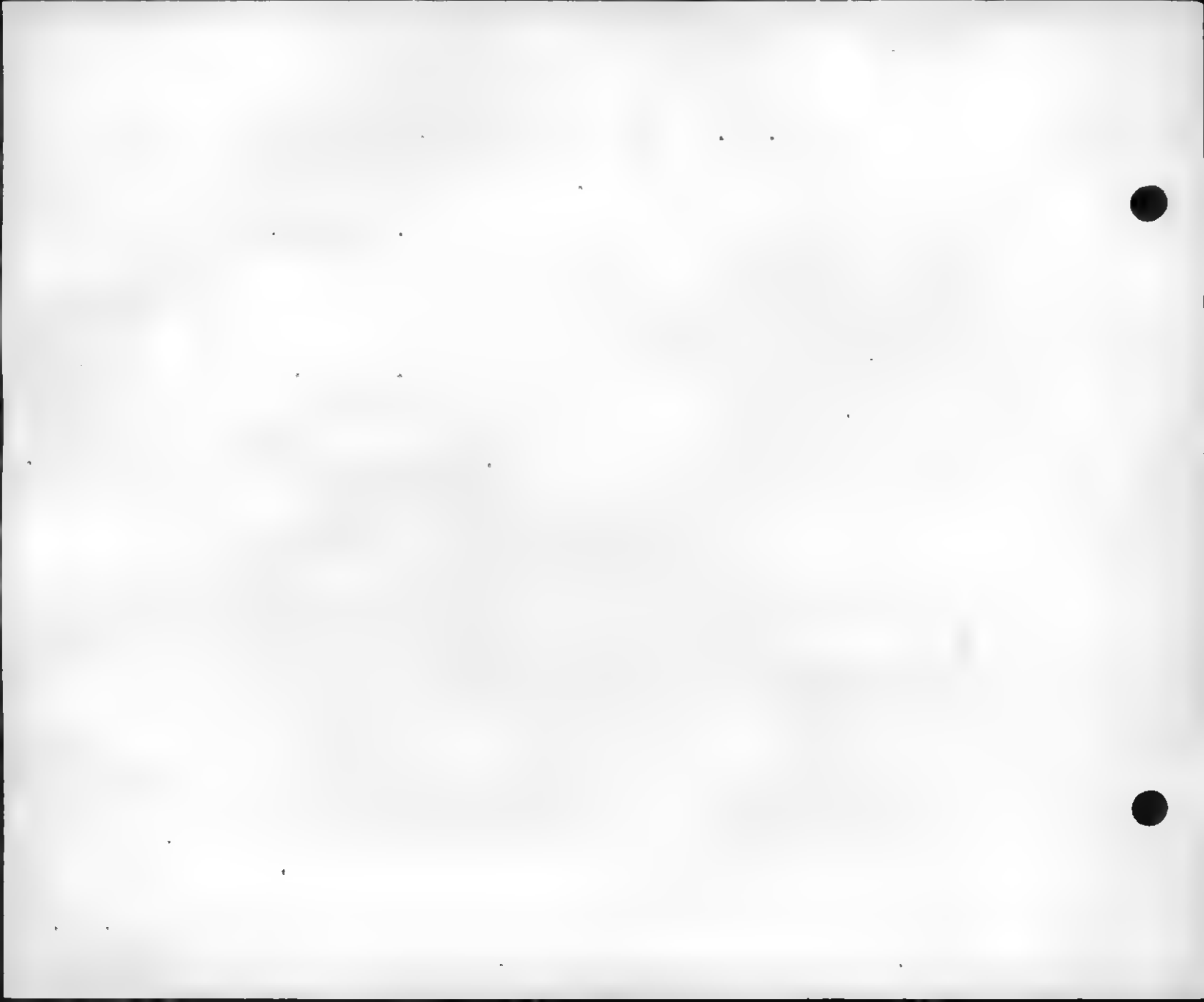
06591

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06589

1 PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Balto</u> b. COUNTY <u>Maryland</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2517 Maryland ave</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>5 mon.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chesapeake Manor Nursing Home</u>		d. STREET ADDRESS <u>509 E. Joppa RD.</u>	
3. NAME OF DECEASED (Type or print) <u>Florence A. Mehlgarten</u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1969</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-1878</u>
9. AGE (In years last birthday) <u>90</u> yrs		10. UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. city Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles A. Mehlgarten</u>		14. MOTHER'S MAIDEN NAME <u>Alvina Vogel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-48-4760</u>	
17. INFORMANT <u>Mrs. Elise Anagnost</u>		Address <u>1906 Alto Vista Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 36 hrs. DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio sclerotic cardio-</u> DUE TO <u>renal-vascular disease</u> (c) <u>10+ yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/8/</u> , 19 <u>69</u> , to <u>5/31</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 23</u> , 19 <u>69</u> , and that death occurred at <u>3:20 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Charles F. O'Donnell</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		22d. ADDRESS <u>7501 York Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 2 1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery Woodlawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Co. Md.</u>
24. FUNERAL DIRECTOR <u>John T. Stansbury</u>		25a. RECD BY REGISTRAR <u>JUN 2 1969</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

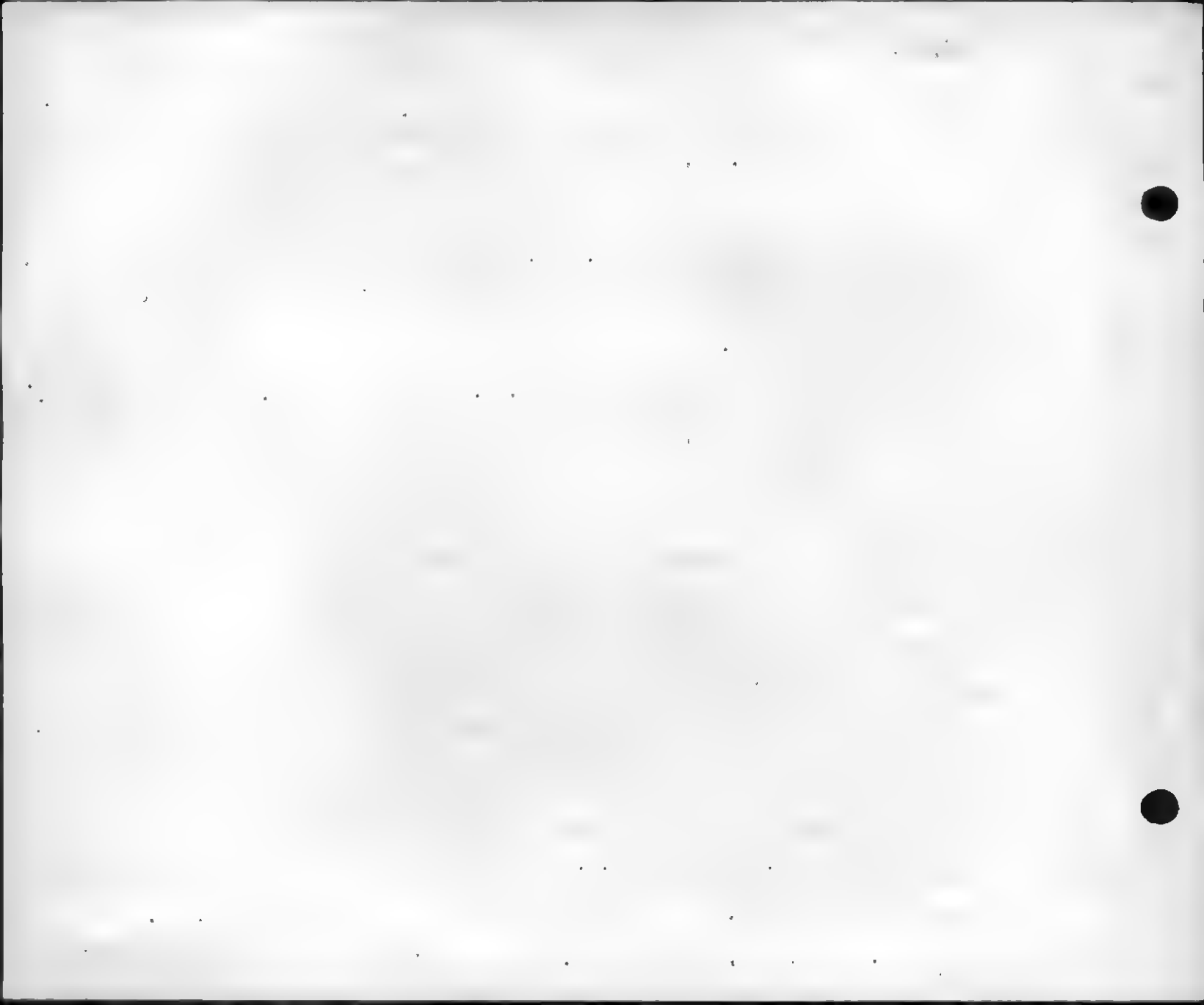
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TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06592

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06590

1 DECEASED NAME (Type or Print) CLARENCE PIERCE MILES, SR.			2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year May 3 1969			2b HOUR OF DEATH ESTIMATED <input type="checkbox"/> 3:36 A.M.		
3 SEX Male	4 RACE White	5 DATE OF BIRTH Aug. 12, 1904	6 AGE (in years last birthday) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year May 3 1969		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balt. Med. Center			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Retired Wire Chief--Telephone Co.		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Maryland			13b COUNTY Baltimore	13c CITY OR TOWN Baltimore	3d INSIDE CITY AREA? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 2300 Taylor Avenue		
14 FATHER'S NAME First Middle Last DuPlessis M. Miles			15 MOTHER'S MAIDEN NAME First Middle Last Sarah Dougherty					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO 212-03-6694		17 INFORMANT ADDRESS Mr. C. Pierce Miles, Jr. 4410 Hyattsville, Md. Oglethorpe St.			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 816.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 1:30 PM 5-3 19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of car which left Expressway and overturned				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f LOCATION Street or R.F.D. No. Route 83 south of route 45		City or Town Baltimore		State Md.
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles S. Springate M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED May 3, 1969		
EXAMINER'S NAME (Type) Charles S. Springate, M.D.			ASS STANT MED. CA. EXAMINER <input checked="" type="checkbox"/>			DEPUTY MED. CA. EXAMINER <input type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b DATE 5/6/69.		23c NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Baltimore, Md. 21214			ADDRESS		25a REC'D BY REGISTRAR MAY 5 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

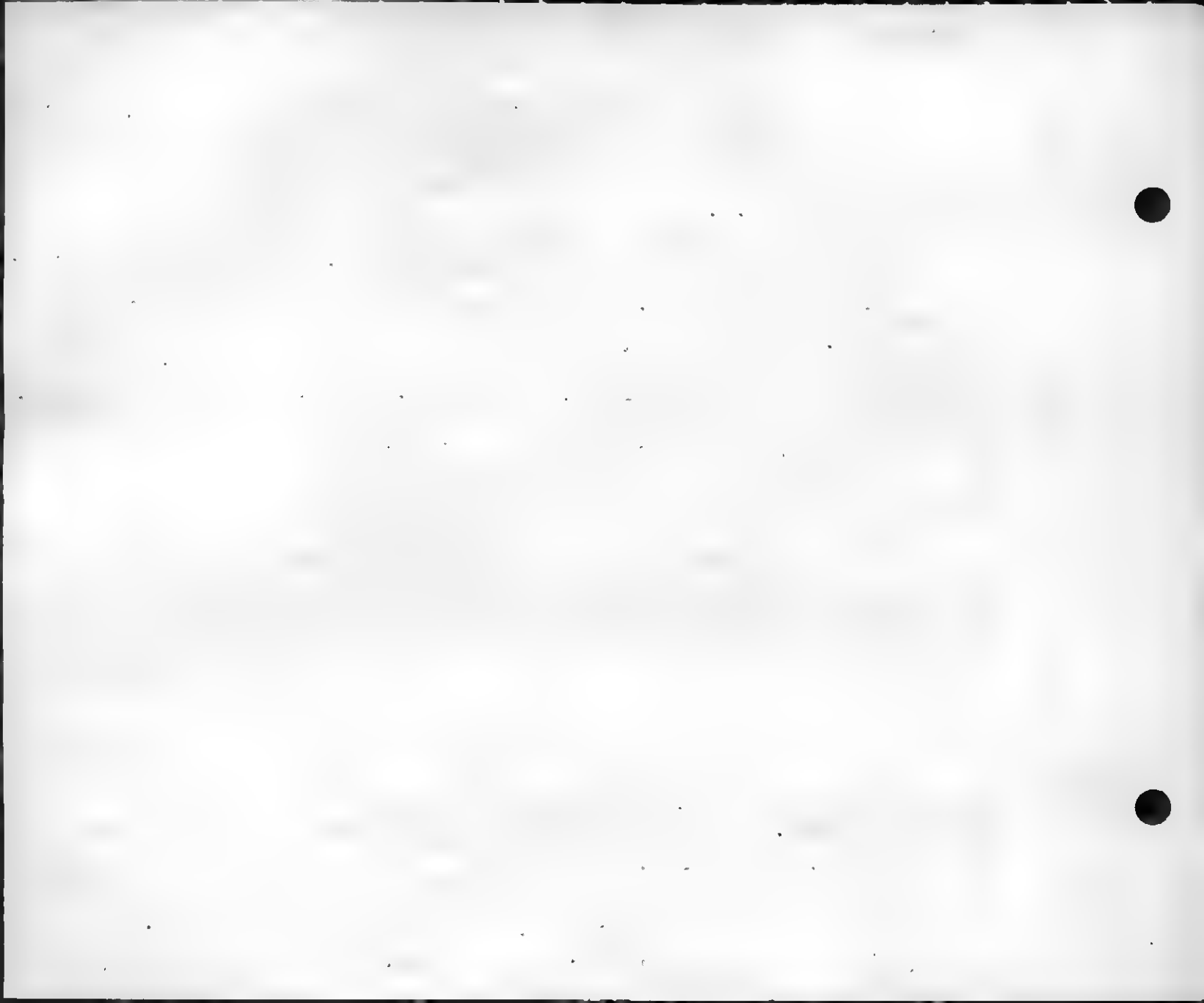


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VR A 15
304 REV 7/68

<div>06593</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>06591</div>									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR		
First Middle Last CHARLES HENRY MILLER					Month Day Year May 3, 1969		7:45		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		white		2/3/1884		85 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore		U.S.				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
		Holly Hill Manor		ret-Lt. Police		Balto. City			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Balto.		Baltimore				15 Maple Ave.	
14 FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Charles Miller				Annie Hall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
no		216-03-8069		Robert C. Miller, son,		21234 2611 Windsor Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Pancrease</u>									
1577 DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.O. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 3, 1969</u> , to <u>May 4, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 4, 1969</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED			
<u>Laurence C. Post</u>		Dr. Laurence C. Post		6805 York Road					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/6/69		Parkwood Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc. 3331 Brehms Lane				MAY 7 1969		<u>Flora Judge</u>			

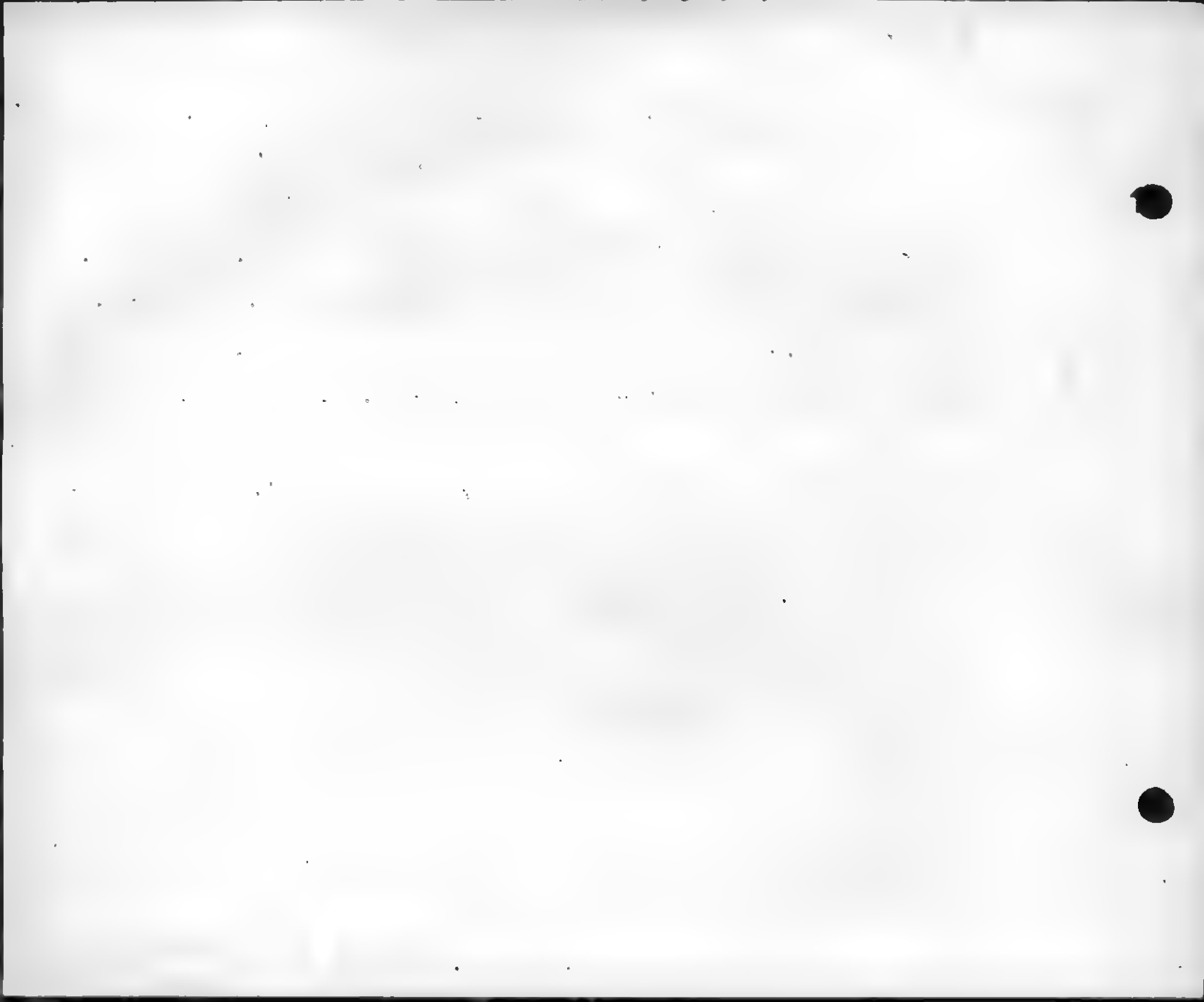


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VR A15 (4)
30M REV. 7-68

06594		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06592	
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
		Charles	S.	Miller	May 20, 1969		2:30 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White	April 6, 1900		69 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland	U.S.A.			Baltimore			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Woodlawn		Ridge Road		Water Dept.		Balto. City	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland				Baltimore		13e. STREET AND NUMBER	
						117 S. Fulton Ave.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
		George M.B.		Miller	Annie T.		Keller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
Yes		212-03-3109		Miss Esther E. Miller		Ridge Rd. 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) CVA							10 days
DUE TO, OR AS A CONSEQUENCE OF							
(b) Generalized Arteriosclerosis							years
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 10-10-1968, to 5-20-1969, that (I) (we) last saw the deceased alive on 5-20-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
Cesar Valle Caverio M.D.		5-21-69		CESAR VALLE CAVERIO			
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS			
		3629 Liberty Rd					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		May 24, 1969		Loudon Park		Baltimore Maryland	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John T. Stansbury, Sr.		-6411 Windsor Mill Rd.		MAY 22 1969		Charles Judge	



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06595

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06593

1 DECEASED-NAME (Type or print) MARY C Miller			2a. DATE OF DEATH Month May Day 18 Year 1969			2b. HOUR 9 PM			
3 SEX female		4 RACE white		5. DATE OF BIRTH 7/16/1916		6. AGE (In years last birthday) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTH PLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALT. CO.			
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 140 m				12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b CITY OR TOWN BALTO.		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER 4104 The Alameda.			
14 FATHER'S NAME First John Middle Miller			15. MOTHER'S MAIDEN NAME First Catherine Middle Hammer						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b SOCIAL SECURITY NO 212-03-6330		17 INFORMANT Address Harry E. Miller 544 Wyanoke Avenue					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease with mitral insufficiency DUE TO, OR AS A CONSEQUENCE OF childhood (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF 5 yrs. (c) Congestive heart failure 1 yr.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July , 19 68 to May 18 , 19 69 , that (I) (we) last saw the deceased alive on May 16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d) (d) (d) view the body after death									
22b. SIGNATURE Lloyd E. Saylor		22c. PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M. D.		22d. ADDRESS 3902 Greenmount Avenue		22e. DATE SIGNED May 19, 1969			
23a. BURIAL CREMAT. REMOVAL (Specify) Burial		23b. DATE May 21, '69		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 W. Baltimore St.		25a. REC'D BY REGISTRAR MAY 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101. Page 5 may be retained for your files.

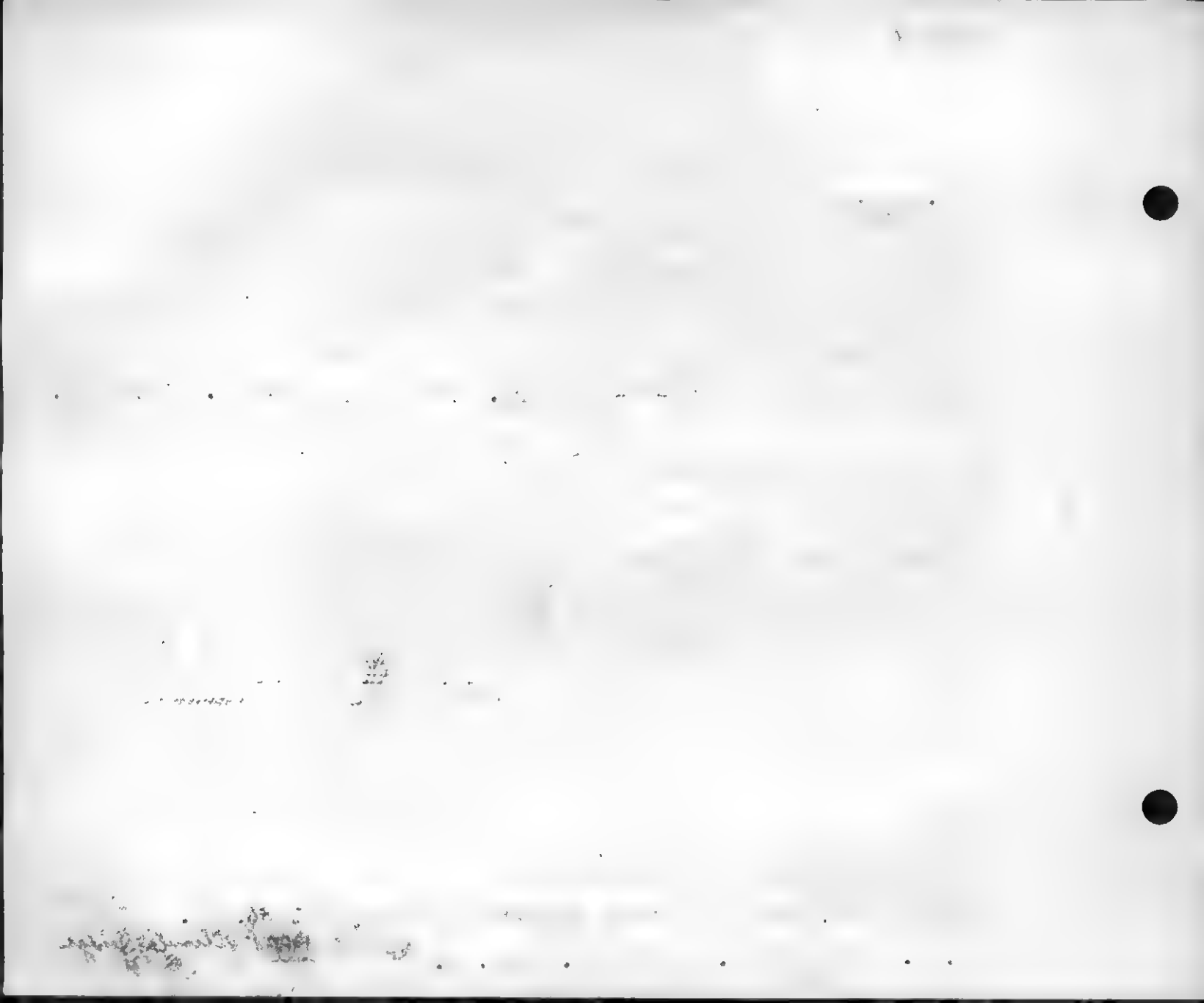
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06596

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06594

1 DECEASED-NAME (Type or Print) First Middle Last HERBERT T. MINOR			2a DATE KNOWN OF ESTI- DEATH MATED Month Day Year May 19, 1969		2b HOUR M A.
3 SEX male	4 RACE negro	5 DATE OF BIRTH 1/9/03	6 AGE (in years last birthday) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS 19 69	IF UNDER 24 HRS. HOURS MIN 19 69
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? United States of America		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH Baltimore			10 CITY OR TOWN OF DEATH Edgemere		
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ft. Howard Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) Maryland			13b CITY OR TOWN Baltimore		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME First Middle Last Unknown			15 MOTHER'S MAIDEN NAME First Middle Last Alice		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO. (If yes give year or dates of service) WWII 220-07-5472		17 INFORMANT ADDRESS Mrs. Knoye Minor 2638 E. Oliver St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subdural Hematoma complicated by Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 768 X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION 3/8/1969		19b CONDITION FOR WHICH OPERATION WAS PERFORMED? assaulted during altercation		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 3:50 P.M. 3/8/1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (At home, farm street, factory, office building, etc.) home		21f LOCATION Street or R.F.D. No City or Town County State 2638 E. Oliver St., Baltimore, Maryland	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 5/20/69	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5/22/69		23c NAME OF CEMETERY OR CREMATORY Balto National Cemetery Balto., Md.	
24 FUNERAL DIRECTOR Wm. C. March 928 E. North Ave. Balto. Md.		ADDRESS		25a REC'D BY REGISTRAR MAY 20 1969	



FOR STATE
HEALTH DEPT.

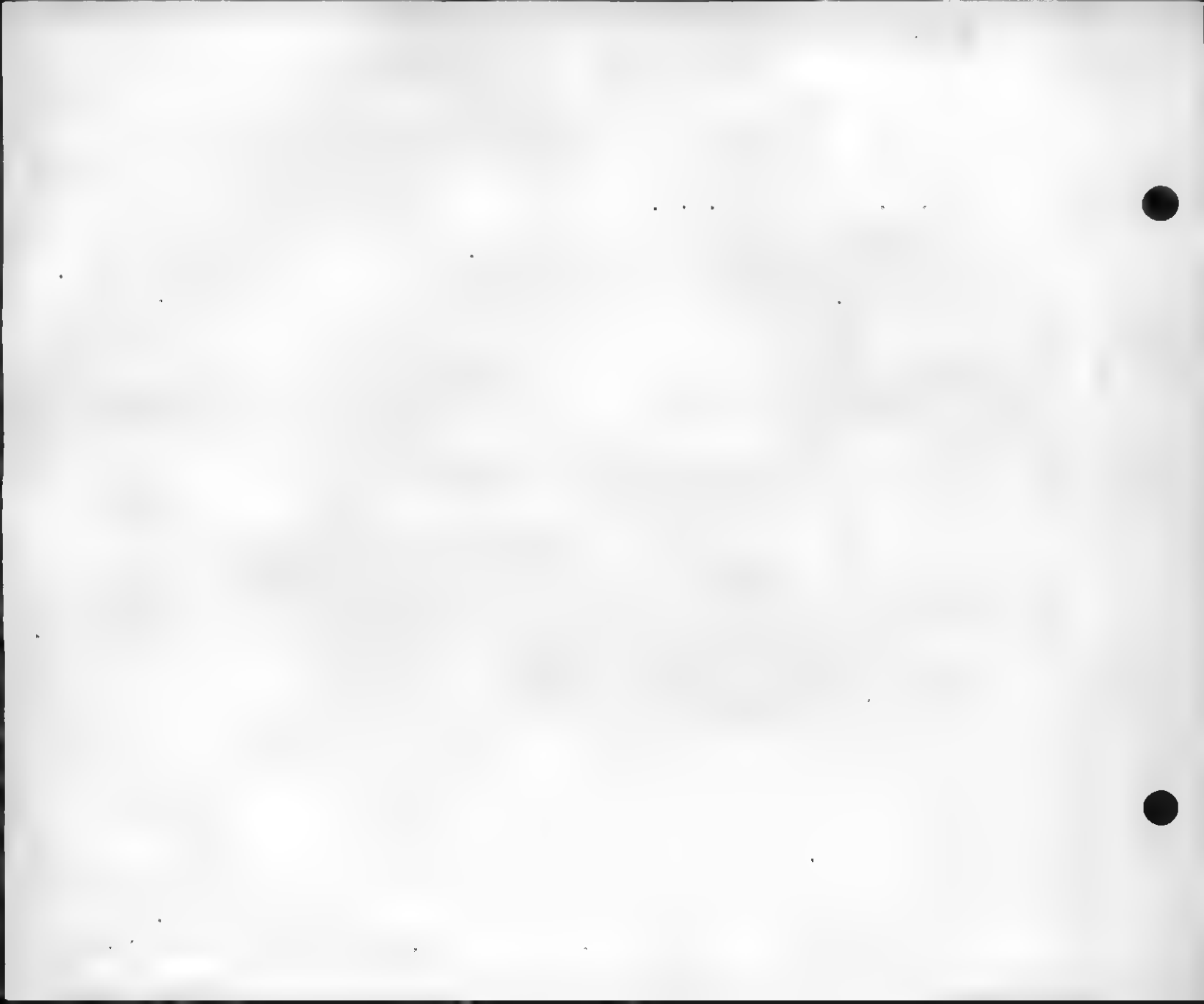
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06597

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06595

1 DECEASED-NAME (Type or Print)		First Middle Last		2a DATE KNOWN OF DEATH		Month Day Year		2b HOUR	
JUSTO		THOMAS		MIRAGLIA		MAY 23 1969		8:00 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	7 UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR	
male	white	2/9/18	51 YRS	MONTHS	DAYS	MAY 23 1969		5:30 P.M.	
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10 CITY OR TOWN OF DEATH			
N. Y.	U.S.A.			Baltimore		Colgate			
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			
7020 Bank St.		Chauffeur-Foreman-Sanitation Dept.				Md. 13b COUNTY Baltimore			
13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		14 FATHER'S NAME First Middle Last			
7020 Bank St.						Joseph Miraglia			
15 MOTHER'S MAIDEN NAME First Middle Last		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
unknown		yes		WW 2		Audrey Miraglia, wife, above			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion									
DUE TO, OR AS A CONSEQUENCE OF (b) A-S-C-V-S disease									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED	
Dr. Melvin B. Davis								MAY 26. 1969	
EXAMINER'S NAME (Type)		ADDRESS		ADDRESS (Street, city, town, or county)		6800 TORNINGTON RD		DUNDALK MD 21222	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		5/27/69		Oak Lawn Cemetery		Baltimore, Md.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc.		3331 Brehms Lane		MAY 28 1969					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06598						CERTIFICATE OF DEATH			06596		
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH			2b HOUR
Bessie		V.		MONTGOMERY		5 Month 29 Day 69			M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		W		11/25/1891		77 YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md		U.S.A				BALTIMORE Md.					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
CATONSVILLE				SUMMIT NURSING HOME				HOUSEWIFE			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm-ss-an) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md				BALTO.		CATONSVILLE		YES <input type="checkbox"/> NO <input type="checkbox"/>		1503 Ridge Rd.	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
First Middle Last				First Middle Last							
William				Dill		Estella					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b SOCIAL SECURITY NO.		17 INFORMANT				Address	
NO						Elizabeth E. Mettee				1105 VERNON AVE.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u>										7 days	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>Arteriosclerotic Cardio-vascular disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Diabetes Mellitus</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f LOCAT ON		Street or R.F.D. No		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>May 29</u> , 19 <u>69</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>May 28</u> , 19 <u>69</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(was)</u> <u>(did)</u> <u>(did not)</u> view the body after death.											
22b SIGNATURE								DEGREE		22c DATE SIGNED	
D.C. MacLaughlin								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		5/29/69	
22d PHYSICIAN'S NAME (Type)								22e ADDRESS			
D. C. MAC LAUGHLIN								303 N. Rolling Rd			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		6/2/69		BALTIMORE NATIONAL		BALTIMORE				Md.	
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
E. S. Mac Nabbs				301 Frederick Rd Baltimore Md				JUN 2 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
06599		06597									
1. DECEASED-NAME (Type or print) First Middle Last Isaac Ernest Moses						2a. DATE OF DEATH Month Day Year May 15, 1969			3b. HOUR a. 8:30 M		
3 SEX Male		4 RACE White		5. DATE OF BIRTH 3/16/87		6. AGE (In years lost birthday) 82 YRS		7. IF UNDER YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Purchasing Agent			12b. KIND OF BUSINESS OR INDUSTRY Heavy Equipment		
13a. USUAL RESIDENCE (Where deceased permanently resided, if institution residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		3d. INSIDE CITY, TOWN OR VILLAGE? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 205 Dunbeath Court			
14. FATHER'S NAME First Middle Last Moses				15. MOTHER'S MAIDEN NAME First Middle Last Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO 159-09-1091-A		17. INFORMANT Address Records--Spring Grove State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia, right lung											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from 7/5/68, 1968, to May 15, 1969, that (X) (we) last saw the deceased alive on May 15, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (d) (d) (did not) view the body after death											
22b. SIGNATURE Rafael H. Marin		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-15-69					
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.				22e. ADDRESS Spring Grove State Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem. Burial		23b. DATE 5/19/69		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill		23d. LOCATION (City or Town) (County) (State) Philadelphia Pa/					
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR MAY 16 1969		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First ALBERT		Middle		Last MUCCI		2a DATE OF DEATH Month 05 Day 02 Year 69		2b HOUR 10:30 AM
3 SEX MALE		4 RACE CAU		5 DATE OF BIRTH July 15, 1900		6 AGE in years last birthday 68 YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE		Md.		
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREAT BALTO. MED. CENTER		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Seaman-Humble Oil Co.		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, first full-time residence before admission) Maryland		13b CITY OR TOWN Baltimore		13c CITY OR TOWN Dundalk		13d SIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 7831 Fairgreen Rd.		
14 FATHER'S NAME First Paul		Middle		Last Mucci		15 MOTHER'S MAIDEN NAME First Mary		Middle		Last ?
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No, or UNKNOWN <input type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO 216-05-8961		17 INFORMANT (Wife) Mrs. Helene E. Mucci,		Address Dundalk, Md.		7831 Fairgreen Rd.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) - PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CA OF LUNG C METASTASIS 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No. 4/26 69		City or Town 5/2 69		County		State
22a I certify that (I) (this hospital) attended the deceased from 4/26 69 , to 5/2 69 , that (I) (we) last saw the deceased alive on 5/2 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Baham Eslami		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 5/2/69				
22d PHYSICIAN'S NAME (Type) B. ESLAMI		22e ADDRESS Greater Balto. Med. Center, Balto. Md.								
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE 5/6/69		23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Md.				
24 FUNERAL DIRECTOR John J. Duda,		ADDRESS 7922 Wise Ave. Dundalk, Md.		25a REC'D BY REGISTRAR MAY 7 1969		25b REGISTRAR'S SIGNATURE William J. Judge				



06601

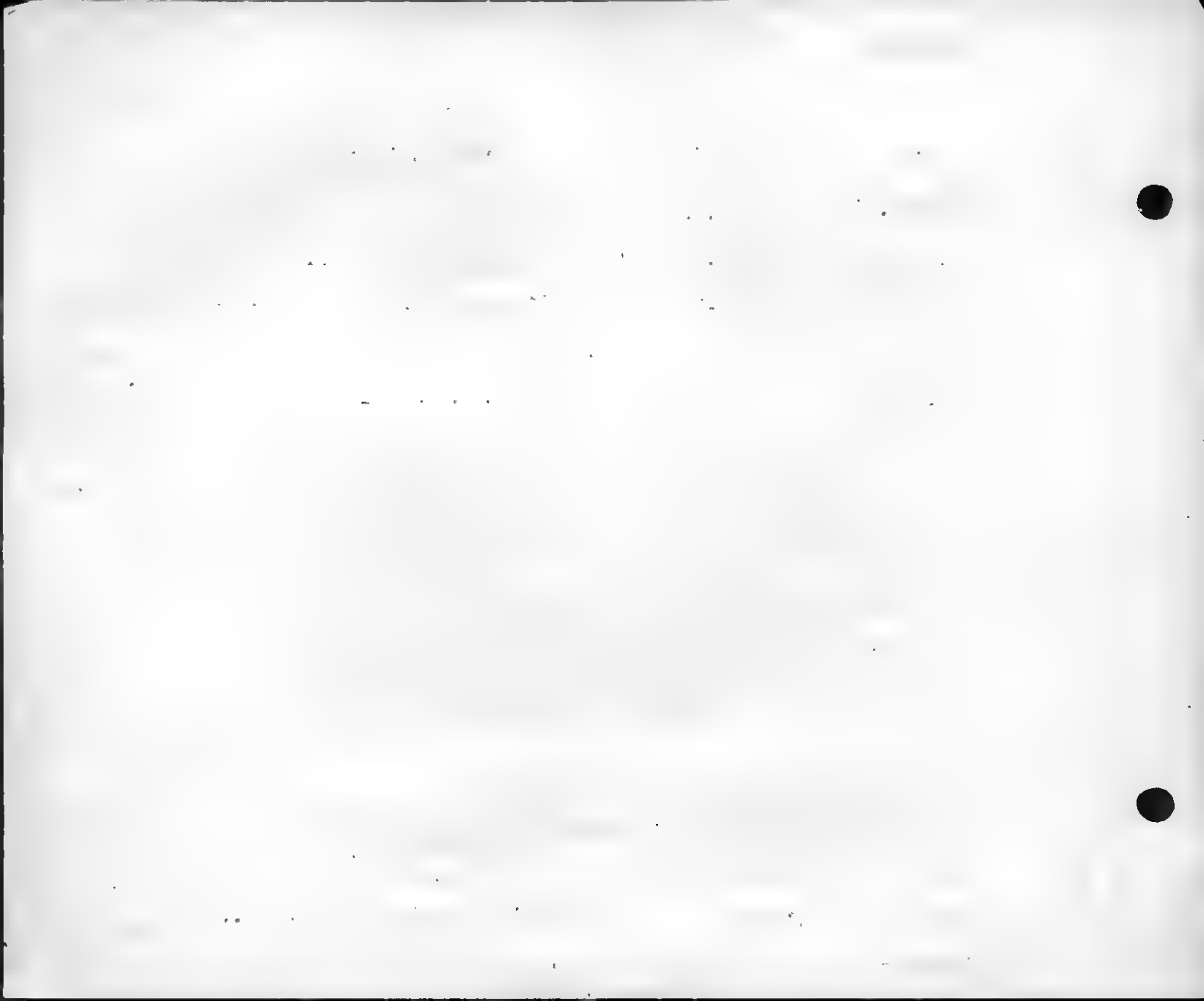
CERTIFICATE OF DEATH

06599

1. DECEASED-NAME (Type or print) ANNA			First A			Middle MULLEN			Last			2a. DATE OF DEATH Month May Day 14 Year 1969			2b. HOUR 10:15 M.		
3. SEX female			4. RACE white			5. DATE OF BIRTH July 28, 1883			6. AGE (In years last birthday) 85 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Balto., Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.								
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 106 St. Martin's Road					
14. FATHER'S NAME First Patrick Middle Hynes Last Hynes			15. MOTHER'S MAIDEN NAME First Ho Middle Nora Last Tuohey														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Mrs. J. N. McCardell (daughter)			Address same								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 11-22 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) A.S.D. Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) A.S.D. Hypertension															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 37 years		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 1937 to May 14, 1969 , that (I) (we) last saw the deceased alive on 5/14 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Samuel P. Alagia			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 5/14/69								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS 3321 Parkview East														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/15/69			23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			23d. LOCATION (City or Town) (County) (State) Balto., Md.								
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home			ADDRESS 6500 York Rd.			25a. REC'D BY REGISTRAR DATE MAY 19 1969			25b. REGISTRAR'S SIGNATURE William R. [Signature]								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15-64
30M REV 1-68

06602

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06600

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) LULA First May Middle Mullinix Last			2a. DATE OF DEATH Month May Day 22 Year 1969			2b. HOUR 7:00 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 7, 1907		6. AGE (In years last birthday) 62 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto Md	
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Teachers Aide	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Charles H. Middle Cook Last			15. MOTHER'S MAIDEN NAME First Elizabeth Middle Shipley Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 3-1-2534		17. INFORMANT Address Mrs. Hazel Philbrick Ellicott City, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGIC PURPURA ENTIRE BODY DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WKS. 6 Mo.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from July 1954 , to May 22, 1969 , that (I) (we) last saw the deceased alive on May 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE: A. V. Houck, MD						22c. DATE SIGNED 5-24-69	
22d. PHYSICIAN'S NAME (Type) R. V. Houck, Jr.				22e. ADDRESS Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-24-69		23c. NAME OF CEMETERY OR CREMATORY Lawrence Park		23d. LOCATION (City or Town) (County) (State) Balto Md.	
24. FUNERAL DIRECTOR Nancy W. Haight Sykesville, Md				25a. REC'D BY REGISTRAR DATE MAY 27 1969		25b. REGISTRAR'S SIGNATURE William J. Judge	

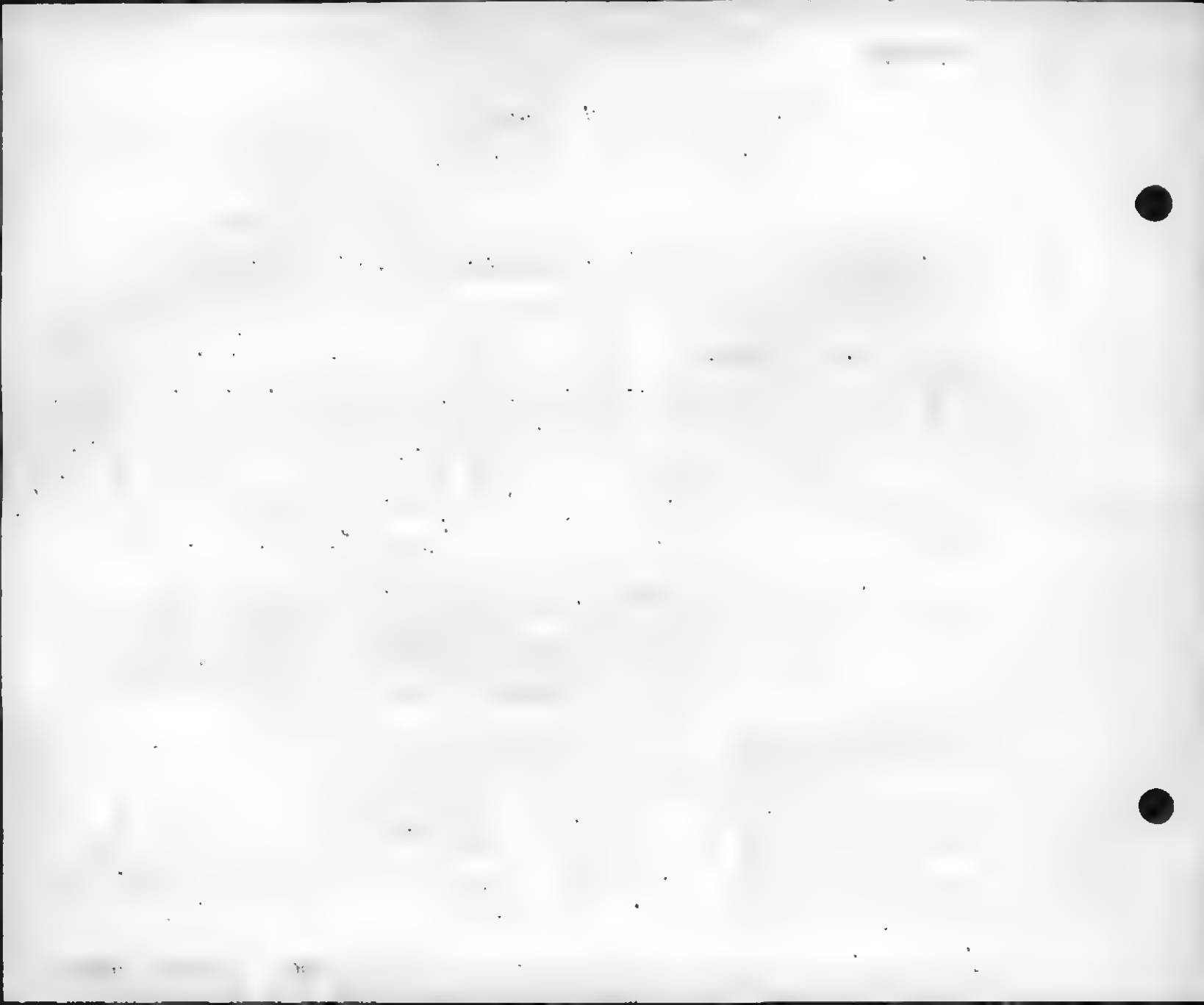
2509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
Ethel E MUMAW						Month Day Year			4:23 PM		
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (n years lost birthday)		
Female			White			27 April 1898			71 YRS		
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Md			USA			Baltimore			Md.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Lutherville			107 Dublin Drive			Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md			Baltimore			2507 Oakley Ave					
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
William HARRIS			Florence Schechter								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO.			17. INFORMANT Address					
No			215099023D			Verle V Edrington 107 Dublin Dr					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Respiratory failure										2 days	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Bacterial pneumonia										2 days	
DUE TO, OR AS A CONSEQUENCE OF											
(c) Diabetes, gangrene of legs										3 months	
(d) Hypertensive heart failure										4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
arteriosclerotic hypertensive cardiovascular disease											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 1965, to May 18, 1969, that (I) (we) last saw the deceased alive on May 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE			22c. DATE SIGNED			22d PHYSICIAN'S NAME (Type)			22e ADDRESS		
Joseph R. Myerowitz M.D.			May 20, 1969			Jos. R. Myerowitz			6615 Reisterstown Rd, Baltimore, Md		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			21 May 69			Baltimore Nat'l Cem			Baltimore Md		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
BURGER Funeral Home Baltimore Md			MAY 22 1969			Charles Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 2a, 2b & 21b

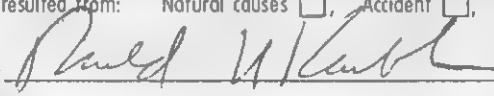

MARYLAND STATE DEPARTMENT OF HEALTH

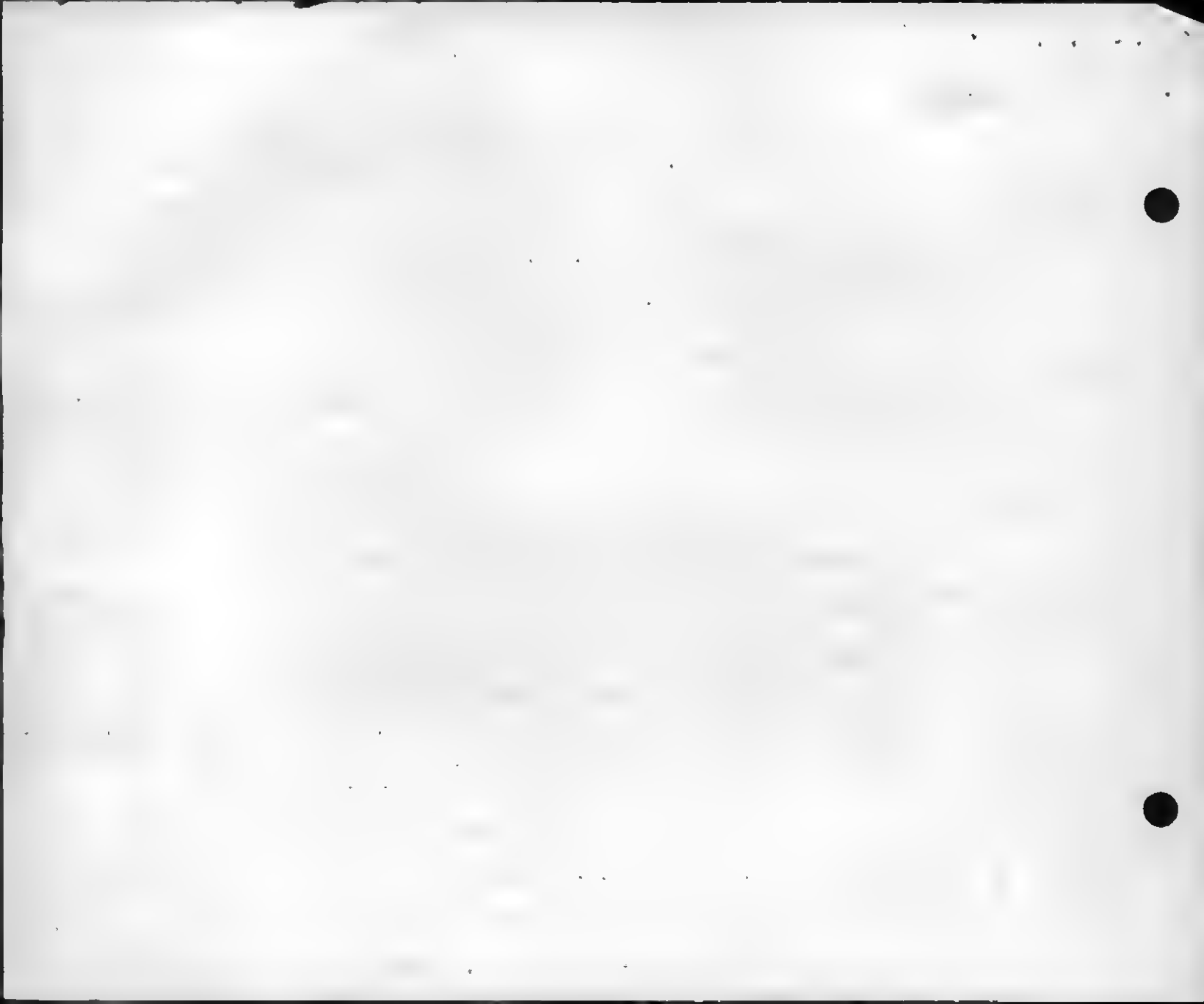
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Film 413 6/18/69

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06602

1. DECEASED NAME FRANCES PATRICIA MURPHY			2a. DATE KNOWN OF DEATH Month 23 Day 22 Year 1969			2b. HOUR P. 5:26 MA		
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 11, 1946	6. AGE (In years last birthday) 23 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month May Day 22 Year 1969		
7a. BIRTHPLACE (State or foreign country) Dublin Ireland		7b. CITIZEN OF WHAT COUNTRY? Ireland		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Balto. Co. General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8401 Liberty Road
14. FATHER'S NAME First Francis Middle Murphy Last Murphy			15. MOTHER'S MAIDEN NAME First Rose Middle ? Last ?			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		
16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Monsignor Murphy			ADDRESS 320 Cathedral St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 8:30 PM 5-22-1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Gunshot wound of head				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) House		21f. LOCATION Street or R.F.D. No. 8401 Libery Rd.		City or Town Balto.		State M.D.
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 5-24-69		
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/28/69		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Old Frederick Rd.		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Krause Funeral Home				25a. REC'D BY REGISTRAR UN 2 1969		25b. REGISTRAR'S SIGNATURE 		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

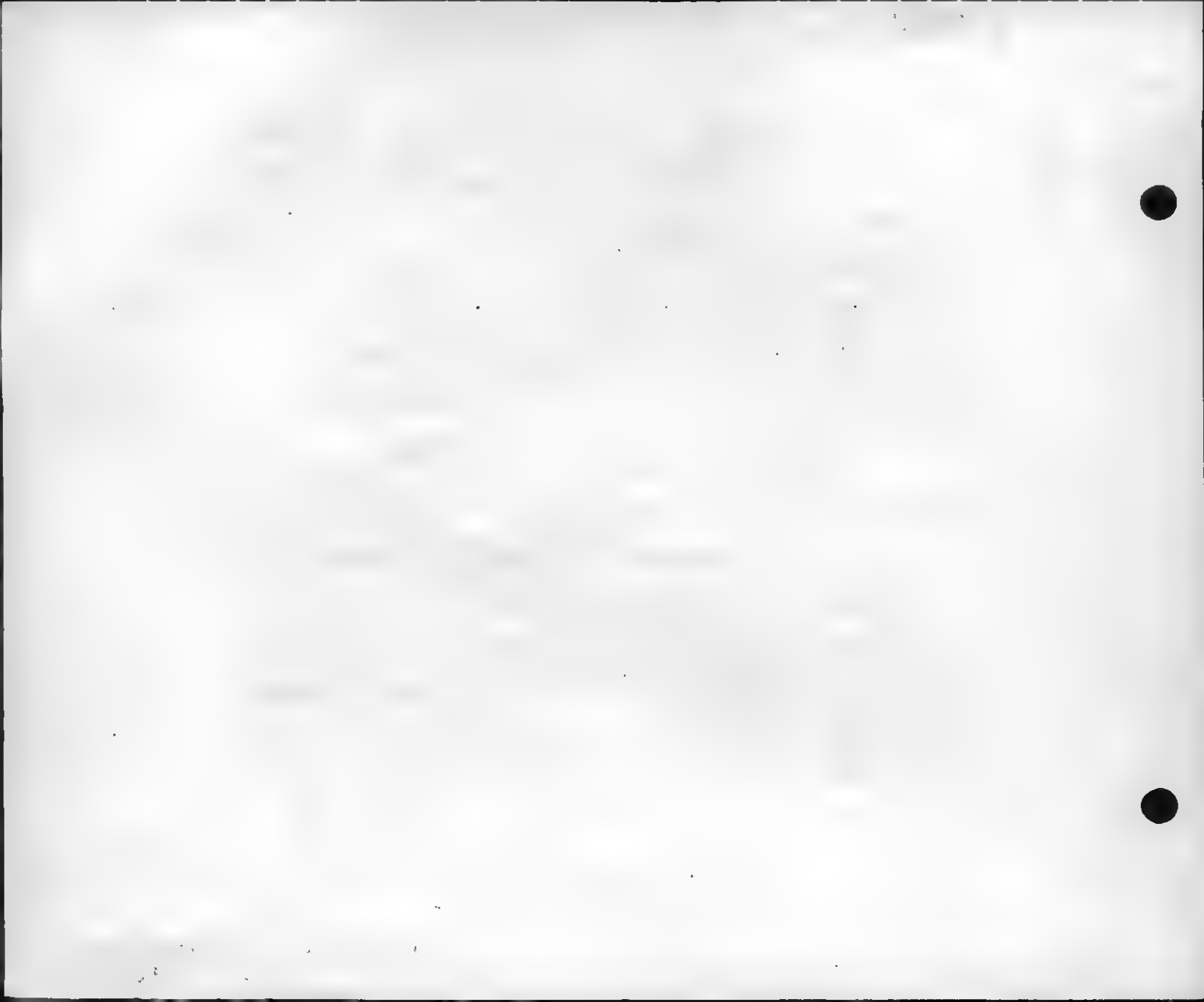
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06605

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06603

1 DECEASED-NAME (Type or Print) JOSEPH HENDRON MURRAY			2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 5 Day 31 Year 1969		2b HOUR 5:10 PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH 12/22/51	6 AGE (In years last birthday) 17 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	7c DATE PRONOUNCED DEAD Month May Day 31 Year 1969
7a BIRTHPLACE (State or foreign country) MD.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH Balto.		10 CITY OR TOWN OF DEATH Edgemere			
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 501 Merritt Lane		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) S.B.		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Balto.	13c CITY OR TOWN Essex Balto.	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 365 Nicholson Rd.
14 FATHER'S NAME First Middle Last WALTER MURRAY			15 MOTHER'S MAIDEN NAME First Middle Last BLANCHE TESTER		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO (If yes give year or dates of service) —		17 INFORMANT JAMES DURIKA	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound of the abdomen</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 8:56 PM 5 31 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Subject broke into residence	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) House		21f LOCATION Street or R.F.D. No City or Town County State 501 Merritt Lane Edgemere Balto. Md.	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b DATE SIGNED May 31, 1969	
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE 6/3/69	23c NAME OF CEMETERY OR CREMATORY SACRED HEART		23d LOCATION (City or town) (County) (State) BALTO. MD.
24 FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE		25a REC'D BY REGISTRAR JUN 3 1969	25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 - and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-55 (4)
304A REV 1/68

06606										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06604																																																											
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
Mildred N. Murray										May 17, 1969										M																																																											
3 SEX										4 RACE										5 DATE OF BIRTH										6 AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.																													
Female										White										Jan. 27, 1901.										68 YRS										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																																																	
Maryland										USA																				Baltimore, Md																																																	
10 CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Timonium										2305 Pot Spring Rd.										Housewife																																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																																							
Md.										Baltimore										Timonium										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										2305 Pot Spring Road																																							
14 FATHER'S NAME										15 MOTHER'S MAIDEN NAME																																																																					
Isaac Lloyd										Jennie Steiner																																																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO										17 INFORMANT										Address																																																	
No																				Mrs. Jane N. Swartz										(Same)																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY.																																																																															
IMMEDIATE CAUSE (a)										Carcinomatosis																																																																					
174x										DUE TO, OR AS A CONSEQUENCE OF																																																																					
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last										(b) Metastasis																																																																					
										DUE TO, OR AS A CONSEQUENCE OF																																																																					
										(c) Ca Of Breast																																																																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
1963										Ca Of Breast										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from 16 May 1969, to May 1969, that (I) (we) last saw the deceased alive on 16 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death																																																																															
22b. SIGNATURE										22c. DATE SIGNED																																																																					
WALTER T. KEES										16 May 1969																																																																					
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
WALTER T. KEES										Cockeysville, Md																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
Burial										5/21/69										Baltimore National										Baltimore, Maryland																																																	
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
Leonard J. Rick Inc.										DATE MAY 20 1969										Balto. Md.																																																											

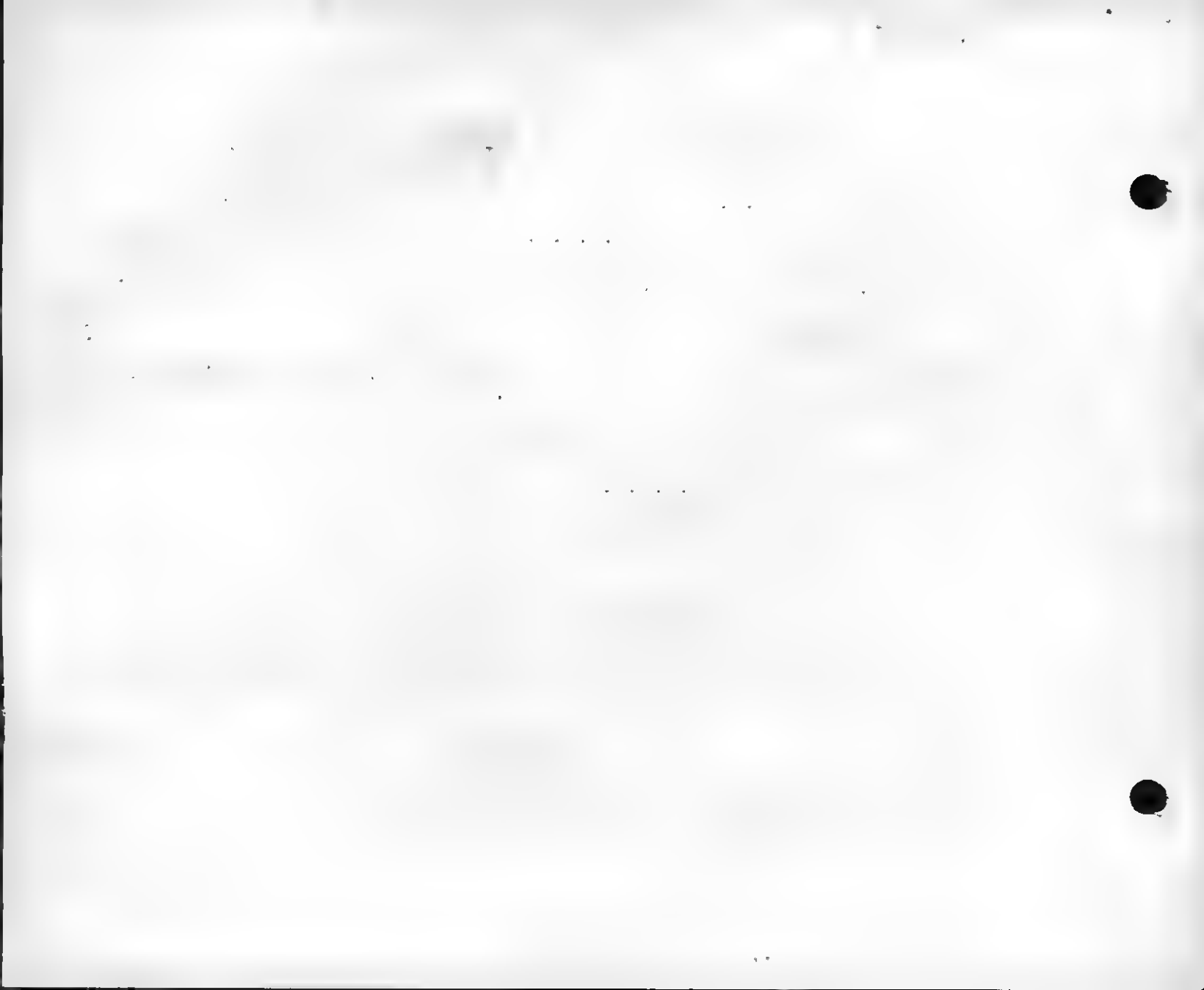


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR
Benjamin		nmi		Muskin				5 Month 17 Day 69 Year		7:30a
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male		White		SEPTEMBER 1891		72 7/7 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Russia		U.S.				Baltimore, County Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Randallstown		B.C.G.H.		FOREMAN		MACHINE SHOP				
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MD.		Balto.		Pikesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3405 Terrapin Rd.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMATION		
MORRIS		MUSKIN		FANNIE		166-01-3630		MRS. BESS LABORWIT, 3405 TERRAPIN ROAD #21208		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) A.S.H.D.										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Bladder Tumor										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
5-16-69		Urinary Retention		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21a. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION		Street or R.F.D. No		City or Town	County	State
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from 5-15-1969, to 5-17-1969, that (I) (we) last saw the deceased alive on 5-18-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS		
L. H. J. J.		5-17-69		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		BALTIMORE COUNTY GENERAL HOSPITAL		
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)	
BURIAL		5-18-69		BETH TFILOH		BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE				
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		MAY 20 1969		M. J. J.						



4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b. HOUR	
Ellen McIlvaine Nelson						May 27, 1969		8 A M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 24 HRS	
F		W		June 23, 1886		82 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10 CITY OR TOWN OF DEATH	
Phila. Pa.		U.S.A.				Baltimore		Stevenson	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. CITY OR TOWN	
Valley Rd. & Park Hghts. Ave.		Homemaker		Own Home		Md.		Baltimore Stevenson	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. CITY OR TOWN		13c INSIDE CITY, APTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		13f. CITY OR TOWN	
Md.		Baltimore Stevenson		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Valley Rd. & Park Hghts. Ave.		Stevenson	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Henry McIlvaine			Fanny Randall						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) No			16b SOCIAL SECURITY NO			17 INFORMANT Address			
			216-01-4804			John M. Nelson, III (Same)			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 acute coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes year									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State					
				June 1968 to May 27, 1969					
22a I certify that (I) (this hospital) attended the deceased from June 1968 to May 27, 1969, and that (I) (my) last saw the deceased alive on 8/26/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.									
22b SIGNATURE		22c. DATE SIGNED		22d PHYSICIAN'S NAME (Type)					
William F. Fritz		5/27/69		Dr. William F. Fritz					
22e ADDRESS		22f. ADDRESS							
		2 W. University Pkwy.							
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		5/29/69		St. Thomas'		Garrison Forest, Md.			
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		MAY 28 1969		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

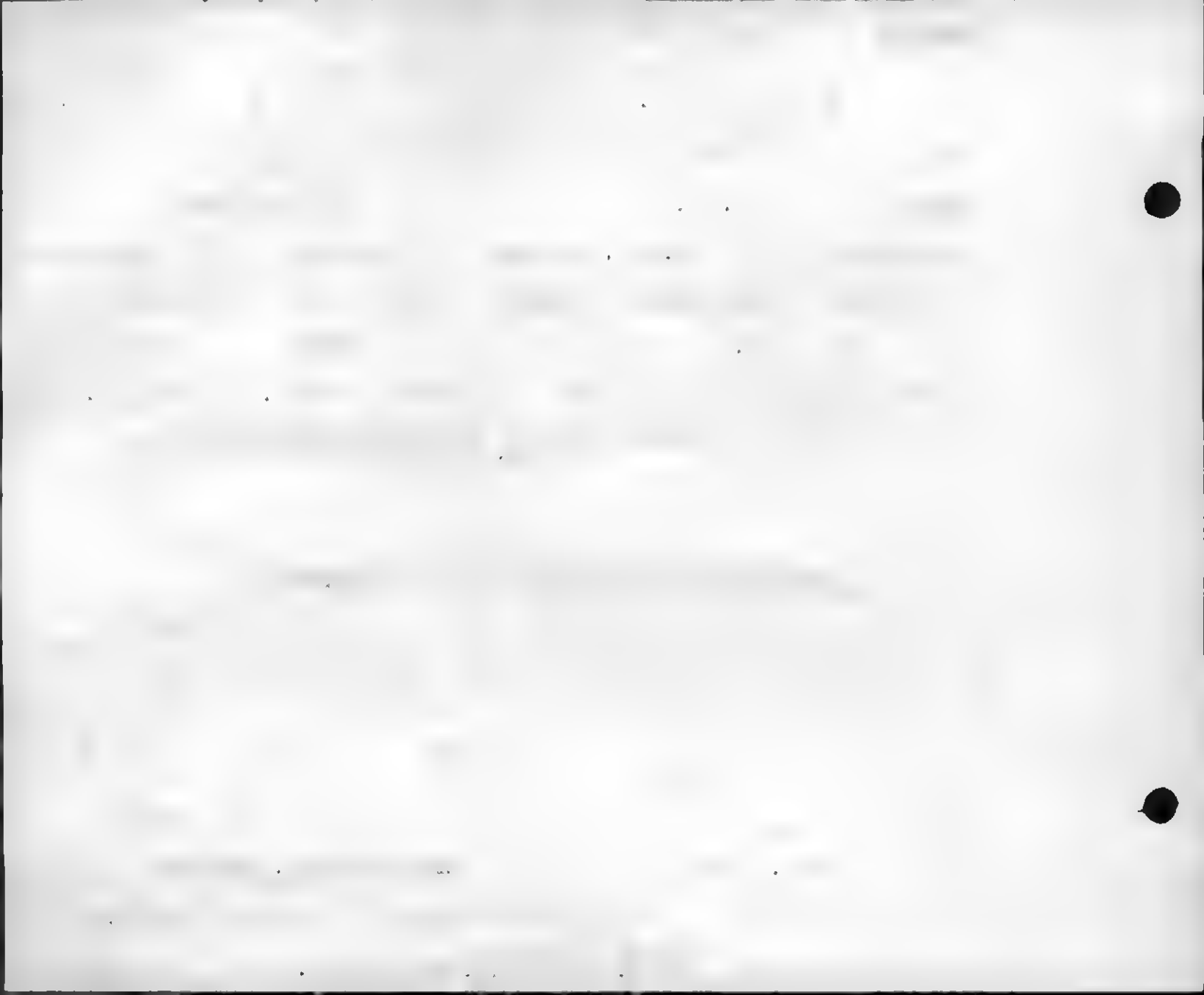
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06609										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06607																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
EIMER FRANKLIN NESS										05 Month 20 Day 69 Year										1:35A M																																							
3. SEX MALE										4. RACE CAU										5. DATE OF BIRTH 05-01-97										6. AGE (In years last birthday) 72 YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH BALTIMORE CO.										Md																			
0. CITY OR TOWN OF DEATH TOWSON, MD.										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GRTR. BALTO. MED CNTR.										12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Bartender										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland										13b. COUNTY 13c. CITY OR TOWN Baltimore										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 3519 Chestnut Ave. 21211																													
14. FATHER'S NAME First Middle Last Joseph Ness										15. MOTHER'S MAIDEN NAME First Middle Last Alban																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No										16b. SOCIAL SECURITY NO. 218-09-6637										17. INFORMANT Mrs. Mary Ness										Address 3519 Chestnut Ave. 21211																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF LUNG										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH APPROX. 6WKS																																							
1621										DUE TO, OR AS A CONSEQUENCE OF PNEUMONITIS AND PLEURAL EFFUSION																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF PULMONARY EDEMA																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 4-11-1969, to 5-20-1969, that (I) (we) lost the deceased alive on 5-19-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Syungsoo Kim										DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>										22c. DATE SIGNED 5-20-69																																							
22d. PHYSICIAN'S NAME (Type) SYUNG SOO-KIM										22e. ADDRESS 6701 N. CHARLES STREET, TOWSON, MD.																																																	
23a. BURIAL CREMATON, REMOVAL (Specify) Burial										23b. DATE May 23, 1969										23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem										23d. LOCATION (City or Town) (County) (State) Woodlawn Balto, Md/																													
24. FUNERAL DIRECTOR Frank R. Seitz										ADDRESS 814 W 36th St.										25a. REC'D BY REGISTRAR DATE 23 1969										25b. REGISTRAR'S SIGNATURE K. Charles Judge																													



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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06610										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06608									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last HAL E. NYE										Month Day Year 5 9 69										7:45AM									
3. SEX MALE					4. RACE WHITE					5. DATE OF BIRTH 1/3/90					6. AGE (In years last birthday) 79 YRS					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (State or foreign country) MONTANA					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH BALTIMORE COUNTY														
1d. CITY OR TOWN OF DEATH FORT HOWARD					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL					12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER					12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND					13b. CITY OR TOWN HARWOOD					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER ROUTE 1, BOX 156														
14. FATHER'S NAME First Middle Last HAL B. NYE					15. MOTHER'S MAIDEN NAME First Middle Last HELENA KLECKNER																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES					16b. SOCIAL SECURITY NO. 218 12 92 43					17. INFORMANT Address CLIN. RECORDS, VA HOSP. FT HOWARD, MD.																			
18. CAUSE OF DEATH (Enter only one cause per PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PANCREAS WITH METASTASIS TO LUNGS, LIVER AND REGIONAL LYMPH NODES										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
1517 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLEROTIC HEART DISEASE. CHRONIC PYELOPHRITIS																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I)(X) this hospital attended the deceased from 3/27/69 , 19____, to 5/7/69 , 19____, that (I)(we) last saw the deceased alive on 5/7/69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I)(we) (did) (do not) view the body after death.																													
22b. SIGNATURE John D. Talbert, MD										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 5/7/69														
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT										22e. ADDRESS VAH FORT HOWARD, MARYLAND																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE 5/9/69					23c. NAME OF CEMETERY OR CREMATORY CHRIST CHURCH CEMETERY					23d. LOCATION (City or Town) (County) (State) OWENSVILLE, MARYLAND														
24. FUNERAL DIRECTOR ANN ZANNINO										ADDRESS ZANNINO FUNERAL HOME 257 S. CONKLING ST. BALTIMORE, MD.					25a. REC'D BY REGISTRAR 16 1969					25b. REGISTRAR'S SIGNATURE Charles Judge									

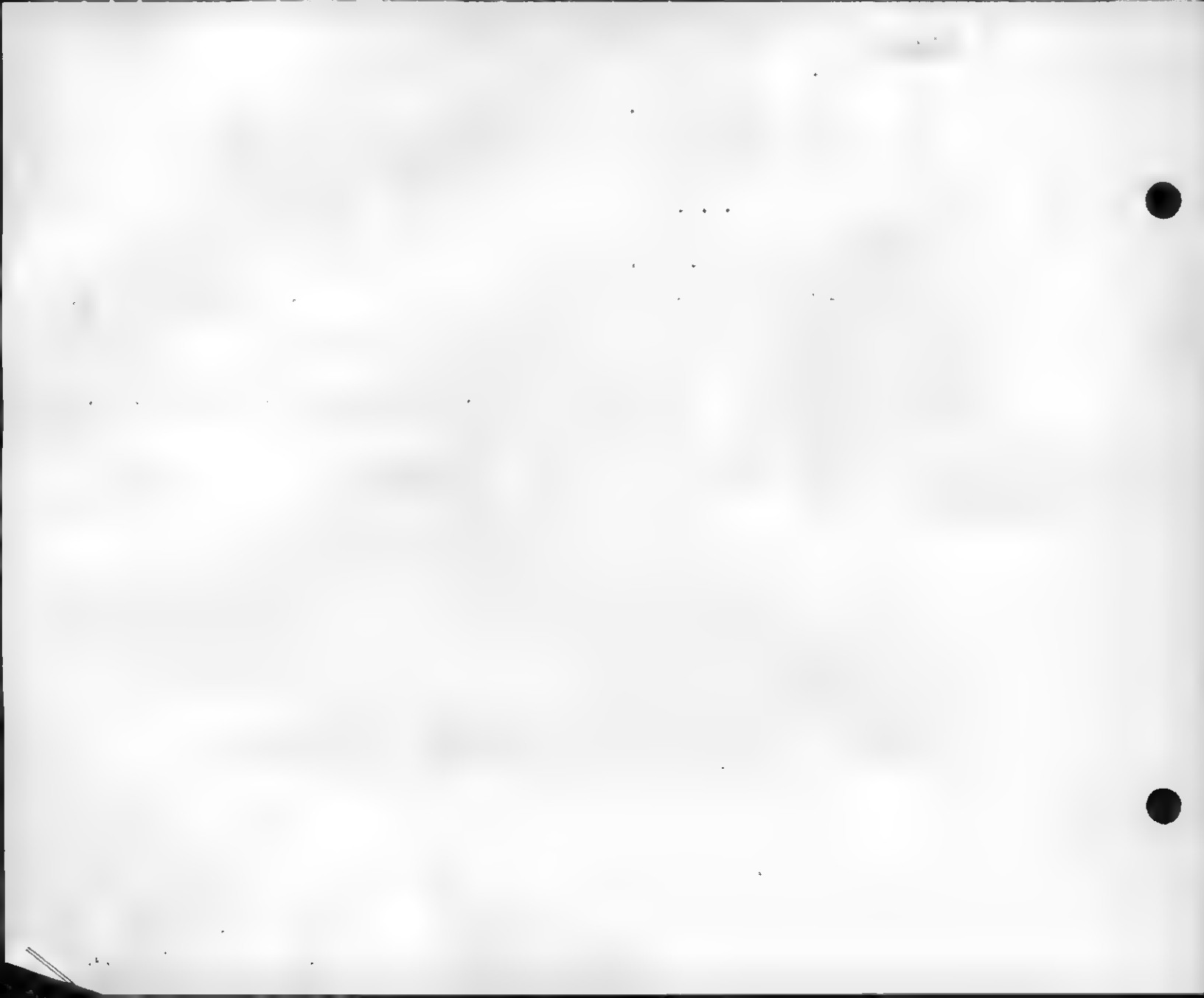


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
45M 11/23/69

06611										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06609									
1 DECEASED NAME (Type or print)										2a DATE OF DEATH										2b HOUR									
JOHN F. OBERY										Month 5 Day 21 Year 69										1:00P M									
3 SEX MALE					4 RACE WHITE					5 DATE OF BIRTH 5/10/87					6 AGE (In years lost birthday) 82 YRS					7 UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN				
7a BIRTHPLACE (State or foreign country) MARYLAND					7b CITIZEN OF WHAT COUNTRY? U.S.A.					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH BALTIMORE														
10 CITY OR TOWN OF DEATH FORT HOWARD					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FLORIST					12b KIND OF BUSINESS OR INDUSTRY FLORIST SHOP														
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND					13b CITY OR TOWN ANNE ARUNDEL					13c CITY OR TOWN ANNAPOLIS					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e STREET AND NUMBER 102 Old Crossing Lane									
14 FATHER'S NAME First Middle Last CHARLES OBERY					15 MOTHER'S MAIDEN NAME First Middle Last BERTHA WEAVER																								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES					16b SOCIAL SECURITY NO. WW 1					17 INFORMANT Address 216 46 66 98 CLIN. RECORDS, VA HOSP. FT HOWARD, MD.																			
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 412.3 DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC HEART DISEASE															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH														
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF YEARS																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NONE														
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>					21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.					21f LOCATION Street or R.F.D. No City or Town County State																			
22a I certify that (I) (this hospital) attended the deceased from 4/3/69, 19, to 5/21/69, 19, that (I) (we) last saw the deceased alive on 5/21/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b SIGNATURE Peter Juvan					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					22c DATE SIGNED 5/21/69																			
22d PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.					22e ADDRESS VAH FORT HOWARD, MARYLAND																								
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL					23b DATE 5-24-69					23c NAME OF CEMETERY OR CREMATORY CEDAR BLUFF					23d LOCATION (City or Town) (County) (State) ANNAPOLIS, MARYLAND														
24 FUNERAL DIRECTOR John M. Taylor					25a RECD BY REGISTRAR TAYLOR FUNERAL HOME ANNAPOLIS, MARYLAND					25b REGISTRAR'S SIGNATURE Charles Judge																			



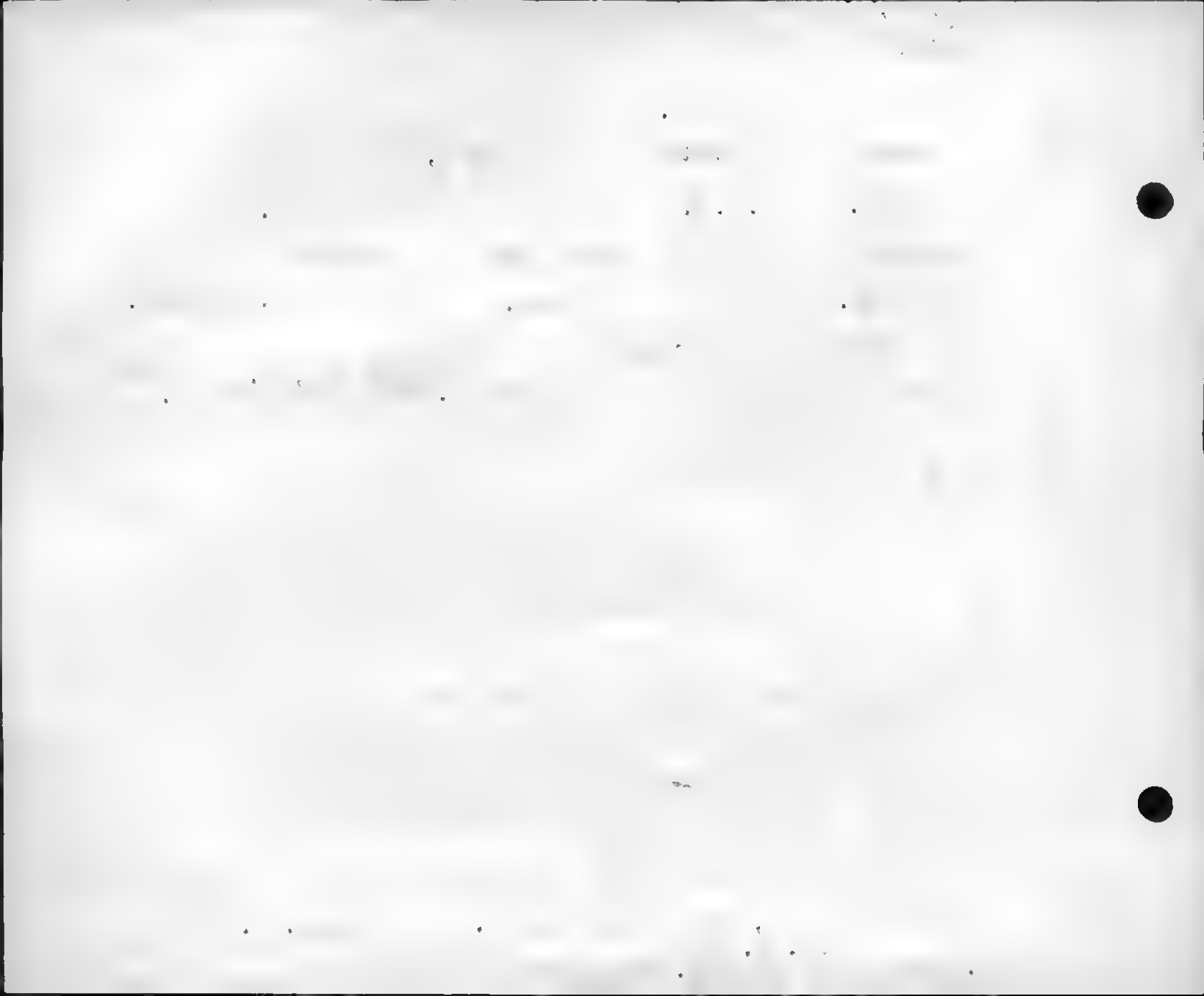
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) Emma M. Oettinger			2a. DATE OF DEATH Month 5 Day 9 Year 1969			2b. HOUR 7:30 A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 7, 1881		6. AGE (In years last birthday) 87 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		
7a. BIRTHPLACE (State or foreign country) Balto.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.				
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. CITY OR TOWN Balto.			13c. INS. DE CITY LIM. TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER 190 S. Kossuth St.	
14. FATHER'S NAME First Edward Middle Hickman Last Josephine			15. MOTHER'S MAIDEN NAME First Josephine Middle Barrick Last Barrick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Ellicott City, Md. Address 21043 Donald C. Oettinger 174 Valley Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 4.9 DUE TO, OR AS A CONSEQUENCE OF, Chronic Lymphatic Leukemia (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.) (b) Chronic Lymphatic Leukemia (c) Chronic Lymphatic Leukemia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 2 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1967 to May 9, 1969 , that (I) (we) last saw the deceased alive on May 8, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE Loudon McKay DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 5-9-69				
22d. PHYSICIAN'S NAME (Type) J. NELSON MCKAY, M.D.						22e. ADDRESS 6014 EDWINSON AVE Balto. Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE May 13, 1969			23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.			23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. National Pike						25a. REC'D BY REGISTRAR MAY 15 1969		25b. REGISTRAR'S SIGNATURE G. Truman Schwab		

MEDICAL CERTIFICATION



1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06613

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06611

1 DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR	
THOMAS		JOSEPH	O'LEARY		MAY Month 28, Day 1969 Year		5:55 A	
3 SEX	4. RACE		5 DATE OF BIRTH		6. AGE (In years lost birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	WHITE		SEPTEMBER 15, 1892		76 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
MARYLAND		U.S.A.				BALTIMORE, Md.		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON		ST. JOSEPH HOSPITAL		POLICEMAN		Law Enforcem.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND				BALTIMORE				319 S. ROBINSON ST., #21224
14 FATHER'S NAME		First	Middle	Lost	15 MOTHER'S MAIDEN NAME		First	Middle
Thomas		J.	O'Leary		Johanna		T.	Finn
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
No		218-28-1159		Robert T. O'Leary 3564 Elmora Ave. 21213				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the left lung with widespread metastases								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (if this hospital) attended the deceased from April 27, 1969, to May 28, 1969, that (we) last saw the deceased alive on May 28, 1969 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death								
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)								5-28-69
Samuel Lee, M.D.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5/31/69		Most Holy Redeemer		4430 Belair Rd, Balto, Md.		
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George A. Weber 705 South Ann Street #21231				MAY 29 1969		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

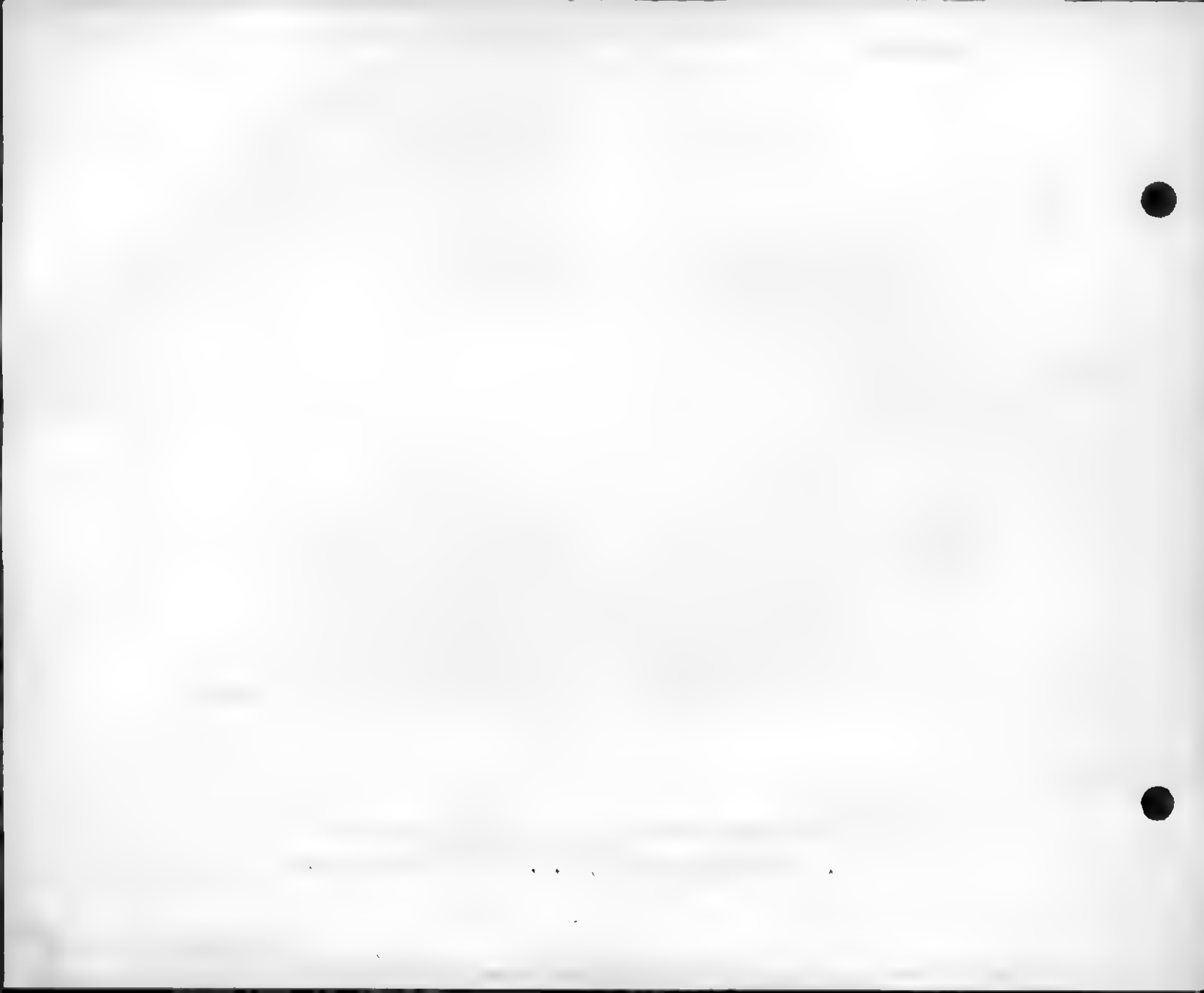
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06614

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06612

1 DECEASED-NAME (Type or print)		First GEORGE		Middle FREDERICK	Last PACKARD	2a. DATE OF DEATH MAY Month 22 Day 1969		2b. HOUR M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH NOVEMBER 7, 1911		6 AGE (In years last birthday) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) NEW YORK		7b CITIZEN OF WHAT COUNTRY? U. S. A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE		Md	
10 CITY OR TOWN OF DEATH TOWSON		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) G. B. M. C.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CLERGY		12b KIND OF BUSINESS OR INDUSTRY CHURCH			
13a USUAL RESIDENCE (Where deceased lived, if institutional, Residence before admission) STATE MARYLAND		13b COUNTY BALTIMORE		13c CITY OR TOWN LUTHERVILLE		13d INS OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 315 VALLEY CT. ROAD	
14. FATHER'S NAME First CHAMPLAIN		Middle PACKARD		Last MARY		15 MOTHER'S MAIDEN NAME First MARY		Middle BURKE	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO (If yes give war or dates of service)		16b SOC. A. SECURITY NO. 212-32-2650		17 INFORMANT Address MRS. KATHERINE M. PACKARD, SAME AS # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Sclerosis Heart Disease</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>Month Day Year</u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>38</u> , to <u>May 22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 22</u> , 19 <u>69</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death									
22b. SIGNATURE <u>W. Grafton Hersperger</u>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>May 23, 1969</u>	
22d. PHYSICIAN'S NAME (Type) W. Grafton Hersperger, M.D.				22e. ADDRESS 214 Medical Arts Building					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAY 26, 1969		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) Woodlawn		(County) (State) Md	
24. FUNERAL DIRECTOR W.N. COOK-BROOKS TOWSON				ADDRESS 1050 YORK ROAD TOWSON, MARYLAND 21204		25a. REC'D BY REGISTRAR DATE MAY 26 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 18 Film 413 6-10-69 a MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Iter 2a Film 413 6/9/69 kk											
CERTIFICATE OF DEATH											
06613											
1. DECEASED NAME First Middle Last Margaret Mary Pass						2a. DATE OF DEATH Month Day Year 5 26 69			2b. HOUR 7:45 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3-24-07		6. AGE (in years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? Maryland U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerical			12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
13a. USUAL RESIDENCE (Where deceased lived, if not at an admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5704 Benton Heights Avenue			
14. FATHER'S NAME First Middle Last George F. McClaskey						15. MOTHER'S MAIDEN NAME First Middle Last Mary Champness					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 217-22-1625		17. INFORMANT Address Charles Pass, husband, above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary right kidney DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from May 13, 1969 , to May 26, 1969 , that (I) (we) last saw the deceased alive on May 26, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Tawee Limpawuchara MD</i>						22c. DATE SIGNED 5/26/69		22d. PHYSICIAN'S NAME (Type) TAWEE LIMPAWUCHARA			
22e. ADDRESS St. Joseph's Hospital											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/31/69		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS Schimineck Funeral Home, Inc. 3331 Brehms Lane						25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE <i>Theresa Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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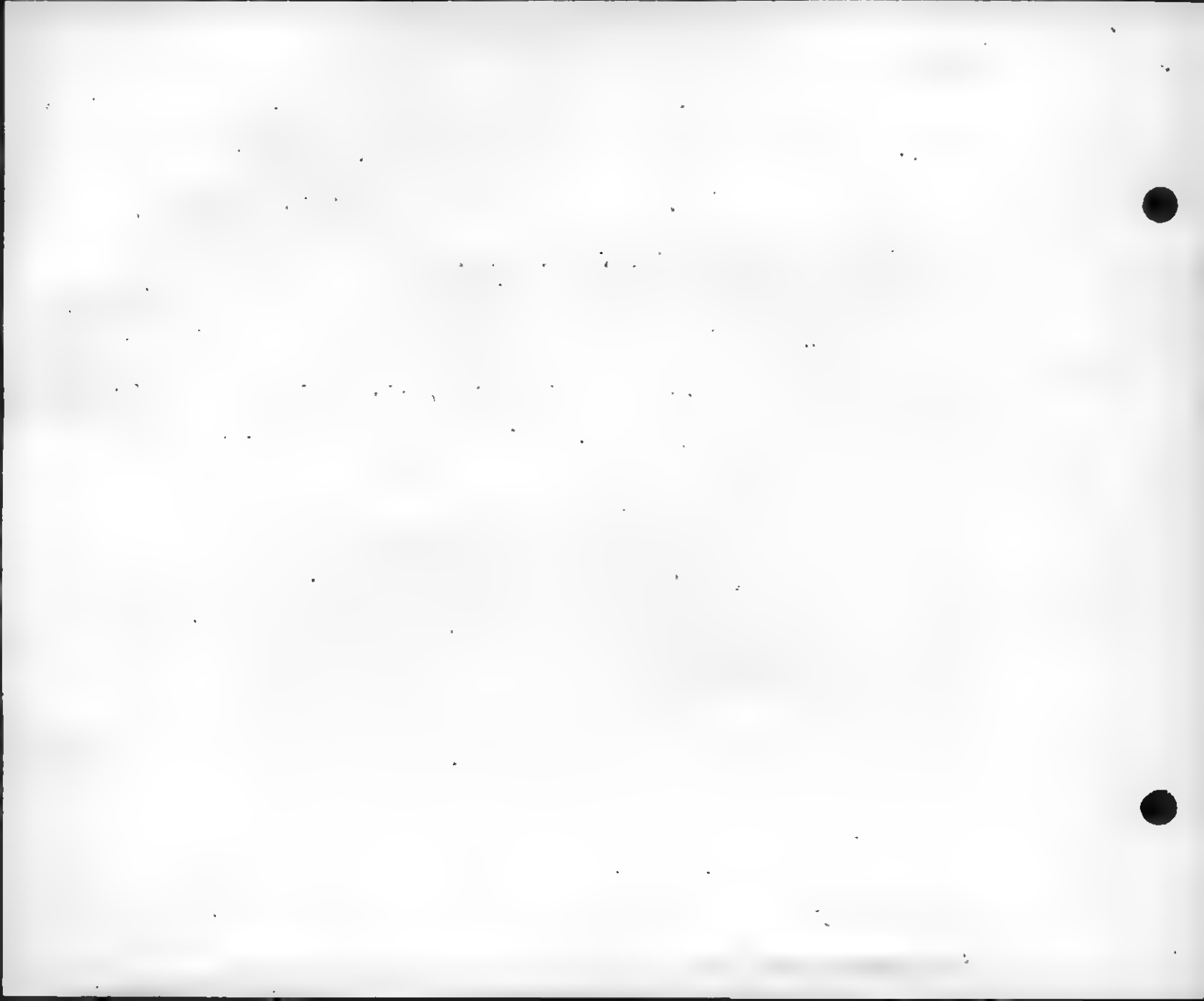
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06616

CERTIFICATE OF DEATH

06614

1. DECEASED-NAME (Type or print) CHARLES First CARL Middle PENNINGTON Last			2a. DATE OF DEATH MAY 27 1969 2b. HOUR 9:05 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 14 Oct 1905	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.		9. COUNTY OF DEATH Baltimore County, Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. CITY OR TOWN ABERDEEN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First WILLIAM Middle PENNINGTON Last NETTIE		15. MOTHER'S MAIDEN NAME First LEE Middle STUART		12a. USUAL PLACE OF WORK (If deceased was doing most of working life, even if retired) CONSTRUCTION	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, Unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 226-09-N09		17. INFORMANT Address Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 412.3 ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC OBSTRUCTIVE LUNG DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4 MAY 1969 to 27 MAY 1969 , that (we) lost saw the deceased alive on 27 MAY 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE W Newcomer				22c. DATE SIGNED 28 May, 1969	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.				22e. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 31 May 1969		23c. NAME OF CEMETERY OR CREMATORY Angel Hill	
24. FUNERAL DIRECTOR Walter Newcomer		25a. REC'D BY REGISTRAR RAM		25b. REGISTRAR'S SIGNATURE John J. Jones	
23d. LOCATION (City or Town) Havre de Grace, Maryland		23e. LOCATION (County) (State)			

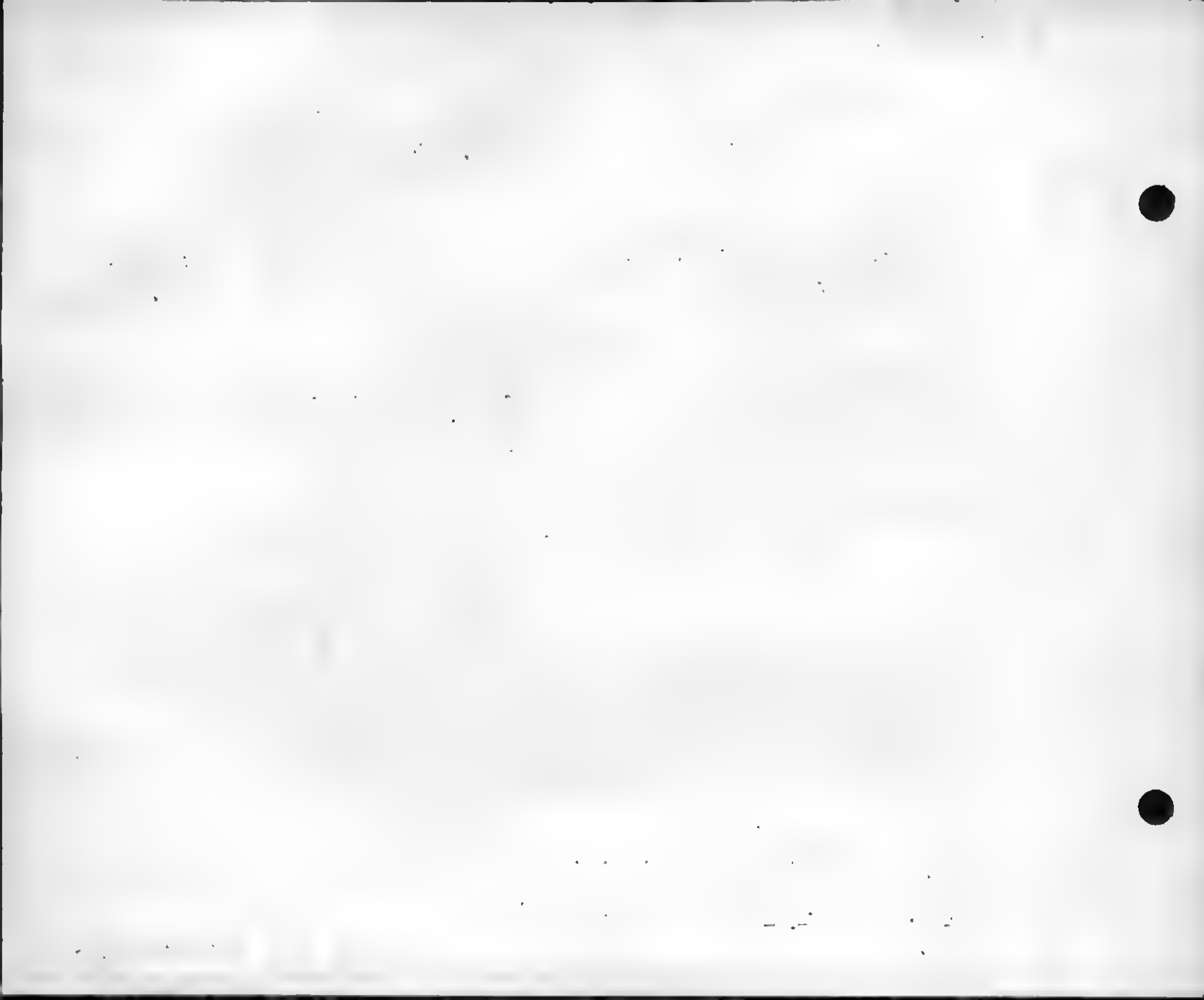


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113 (4)
300M REV. 11-68

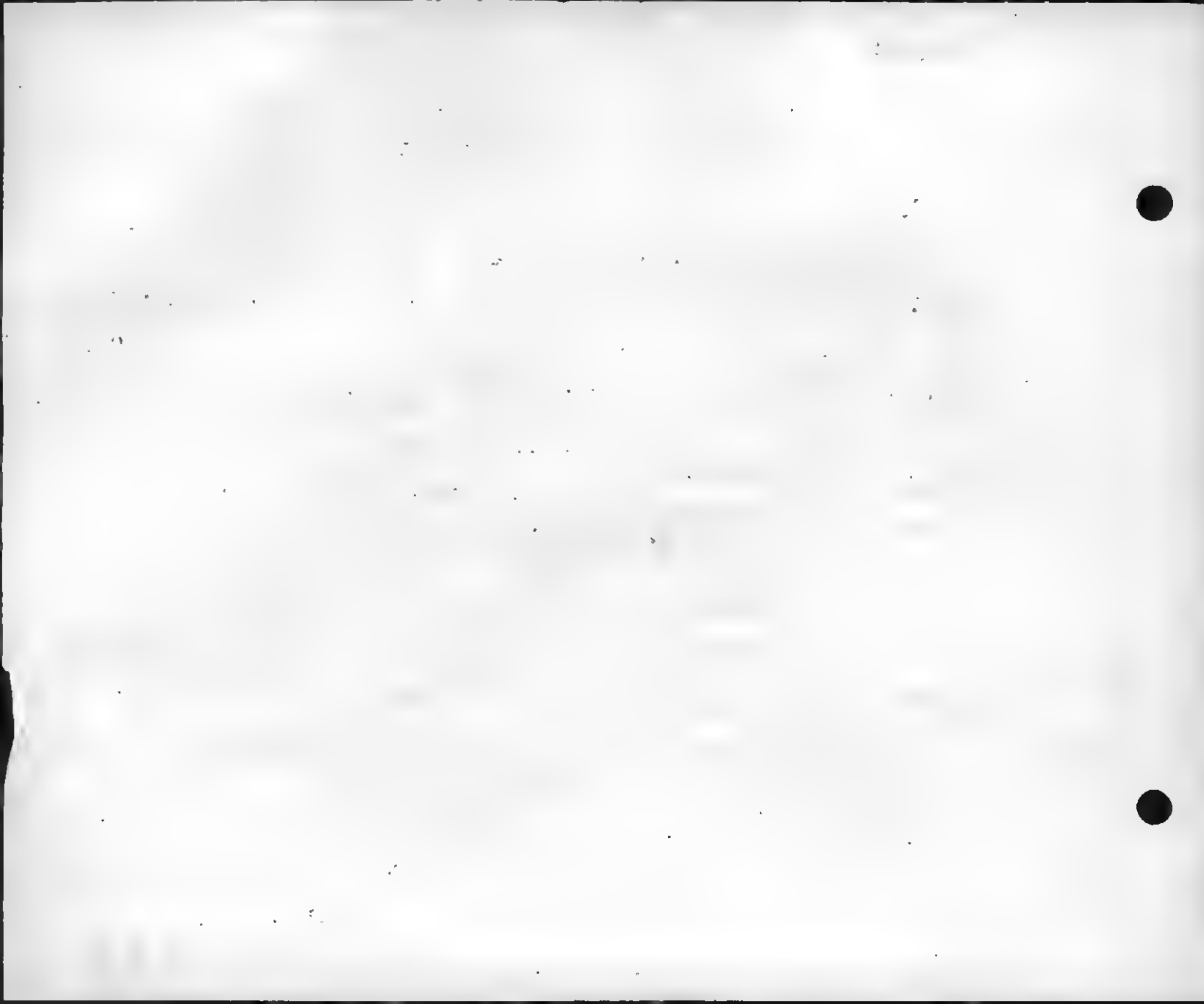
<div>06617</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item #7b, Film G413 6/2/69 km</div> <div>CERTIFICATE OF DEATH</div> <div>06615</div>											
1. DECEASED-NAME (Type or print) First <i>Mary</i> Middle <i>Petratis</i> Last						2a. DATE OF DEATH Month <i>May</i> Day <i>24</i> Year <i>1969</i>			2b. HOUR <i>M</i>		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>Feb. 2 1891</i>			6 AGE (In years last birthday) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>
7a. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Lithuania</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore Co</i> Md					
10. CITY OR TOWN OF DEATH <i>Catonsville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>House wife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Arbutus</i>		13d. INSIDE CITY, Y.N.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5705 Circle Pl. 21227</i>		
14. FATHER'S NAME First <i>Bendjunas</i> Middle <i></i> Last						15. MOTHER'S MAIDEN NAME First <i></i> Middle <i></i> Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <i>no</i> (If yes give war or dates of service) <i>no</i>				16b. SOCIAL SECURITY NO. <i></i>		17 INFORMANT <i>John Petratis, 5705 Circle Pl. Balto 21227</i> Address <i></i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute heart failure</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>A.S.C.U.D.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Senile</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <i></i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOJR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i> P.M. <i></i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) <i></i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE, BUILDING, ETC. <i></i>				21f. LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>1968</i> , to <i>5-24</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>May 24</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stanley Ankudas</i> DEGREE <i></i> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED <i>5/26/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>Stanley Ankudas, M.D.</i>						22e. ADDRESS <i>1101 Maiden Choice Lane #21229</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-28-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Louden Park Cem</i>			23d. LOCATION (City or Town) <i>Balto Md</i> (County) <i></i> (State) <i></i>				
24. FUNERAL DIRECTOR <i>Thomas J. Kenny Inc 1600 Hollins St</i> ADDRESS <i></i>						25a. REC'D BY REGISTRAR <i>MAY 26 1969</i> DATE <i></i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 06618 MARYLAND STATE DEPARTMENT OF HEALTH 06616 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>													
1. DECEASED-NAME (Type or print)			First Laura		Middle Petrone		Last Petrone		2a. DATE OF DEATH Month May Day 26 Year 1969		2b. HOUR p 1:20 M		
3 SEX Female		4. RACE White			5. DATE OF BIRTH 12-3-1891			6 AGE (n years last birthday) 77 YRS		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Italy			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 149 S. Robinson St. 21224			
14. FATHER'S NAME First Carmine Middle Devesu Last Celeste			15. MOTHER'S MAIDEN NAME First Caprariello Middle Caprariello Last Caprariello										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 213 18 6080			17. INFORMANT Address Mrs. Spagnola							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 7710 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Arteriosclerotic cardiovascular disease. Diabetes mellitus.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (this hospital) attended the deceased from May 24, 1969 to May 26, 1969 , that (I) (we) saw the deceased alive on May 26, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Jaime Punzalan						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED May 26, 1969				
22d. PHYSICIAN'S NAME (Type) Jaime Punzalan, M.D.						22e. ADDRESS 7620 York Road, Towson, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/29/69		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer			23d. LOCATION (City or Town) (County) (State) Baltimore					
24. FUNERAL DIRECTOR J. Zanneo			ADDRESS 263 S. Bonding St			25a. REC'D BY REGISTRAR JUN 2 1969			25b. REGISTRAR'S SIGNATURE Charles Judge				



3954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06619					06617					
1 DECEASED NAME (Type or print) ^{First} Elizabeth ^{Middle} Rebecca ^{Last} Pfeiffer					2a. DATE OF DEATH ^{Month} 5 ^{Day} 26 ^{Year} 1969			2b. HOUR 8 A.M.		
3 SEX Female		4 RACE White		5 DATE OF BIRTH 12/22/1907		6 AGE (In years past birthday) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.				
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stella Maris Hospice			12a. OCCUPATION (Kind of work done even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Balto		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3713 Delvern Rd	
14 FATHER'S NAME ^{First} George ^{Middle} T ^{Last} Humerick				15 MOTHER'S MAIDEN NAME ^{First} Ann ^{Middle} L ^{Last} Jackson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 220-34-6618		17. INFORMANT Address Stella Maris Hospice, Towson, Md 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arterial stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr - 4 hrs 4 hrs -	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from July, 1968, to May, 1969, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E. Lee Robbins				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE/SIGNED 5/26/69				
22d. PHYSICIAN'S NAME (Type) E. Lee Robbins				22e. ADDRESS 812 Mockingbird La. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/29/69		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.				
24. FUNERAL DIRECTOR H.N. PEARSON				ADDRESS 205 N. CALVERT ST.		25a. REC'D BY REGISTRAR DATE JUN 3 1969		25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAY 29 1969										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
06620										
06618										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
Sarah Elizabeth Pickett						Month Day Year May 23 1969		8:35P M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 24 HRS		
Female		White		12-29-1883		85 YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS M N		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland			U.S.A.				Baltimore Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph			homemaker		at home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2902 Cub Hill Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last George W. Driver			First Middle Last Mary Poole							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
no			218 10 8473		Mrs. Geo. H. Duerbeck 2902 Cub Hill Rd, Baltimore, Md. 21234					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) #1 Congestive Heart Failure										
4122 DUE TO, OR AS A CONSEQUENCE OF										
(Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last)										
(b) Arteriosclerotic Hypertensive Cardiovascular Disease and Pulmonary Infarction										
DUE TO, OR AS A CONSEQUENCE OF (c) #2 Renal Cell Carcinoma with Liver Metastasis										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>May 12</u> , 19 <u>69</u> , to <u>May 23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 23</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>John L. Feliciano, M.D.</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>						22c. DATE SIGNED 5-24-69				
22d. PHYSICIAN'S NAME (Type) Christine Feliciano, M.D.						22e. ADDRESS 7620 York Rd. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/28/69		Popular Springs		Methodist Popular Springs, Toward, Md.				
24. FUNERAL DIRECTOR ADDRESS Higinbotham Slack Funeral Home Ellicott City, Md.						25a. REC'D BY REGISTRAR MAY 29 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

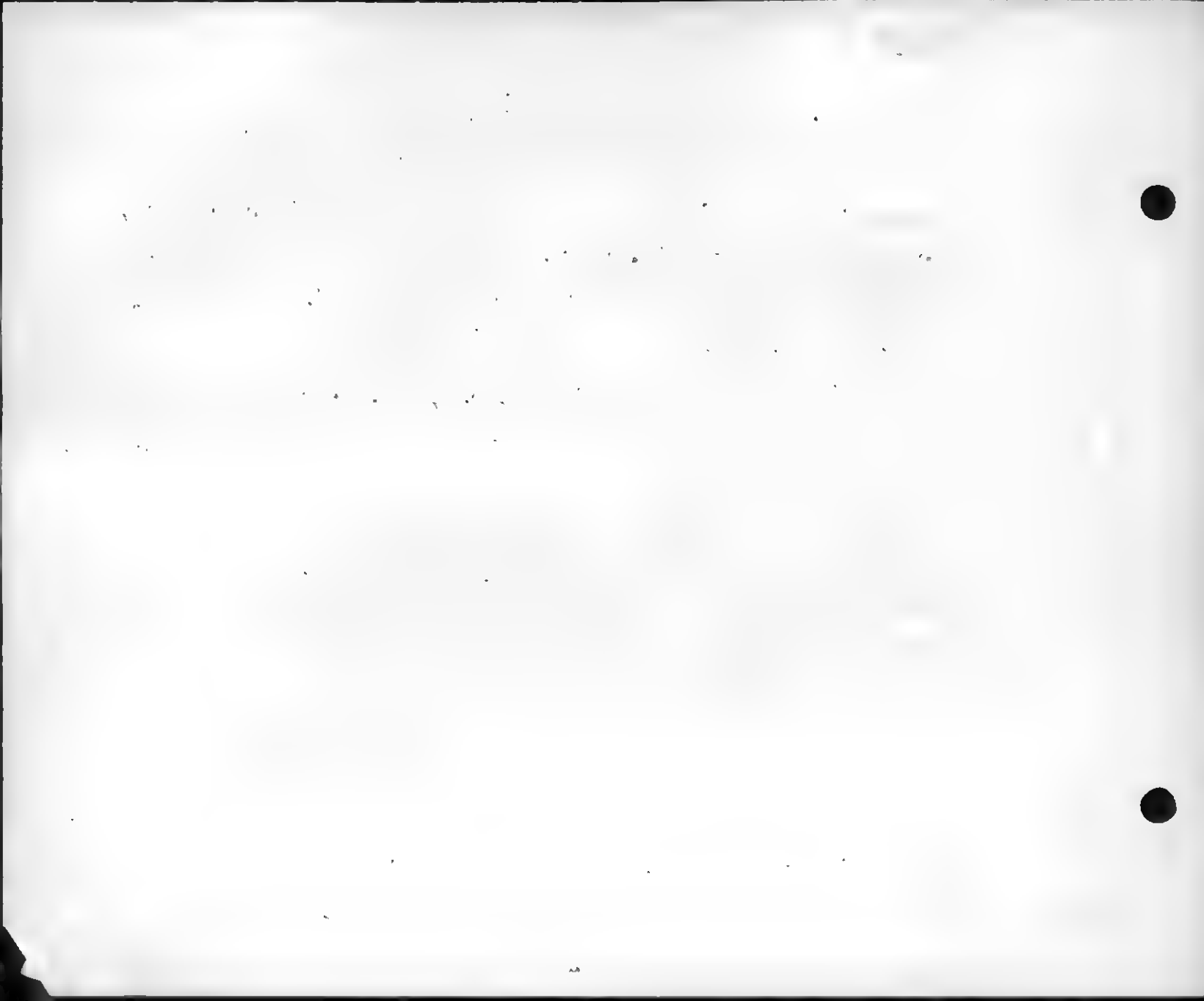
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their files remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06621

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06619

1. DECEASED-NAME (Type or print) First Middle Last JAMES ALLEN PIERCE			2a. DATE OF DEATH Month Day Year MAY 30 1969			2b. HOUR 9:20	
3 SEX Male		4 RACE White		5 DATE OF BIRTH Oct 8, 1895		6 AGE (In years last birthday) 73 YRS	
7a BIRTHPLACE (State or foreign country) N. CAROLINA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.	
10 CITY OR TOWN OF DEATH Mount Wilson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Wood-Working		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b COUNTY 136		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER 3040 WATERVIEW AVE		14 FATHER'S NAME First Middle Last James W. Pierce		15 MOTHER'S MAIDEN NAME First Middle Last Kate Allen			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16b. SOCIAL SECURITY NO. 261-36-2269		17. INFORMANT Address Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF Lung 1121 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Essential Hypertension Auricular Fibrillation							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/22 , 1968, to 5/30 , 1969, that (I) (we) last saw the deceased alive on 5/30 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE W. Newcomer				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/30/69	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.				22e. ADDRESS Mount Wilson, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE June 1, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedarwood Cem. Weldon N. C.		23d. LOCATION (City or Town) (County) (State) Weldon N. C.	
24 FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				25a REC'D BY REGISTRAR DATE JUN 5 1969		25b REGISTRAR'S SIGNATURE William Newcomer	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06622

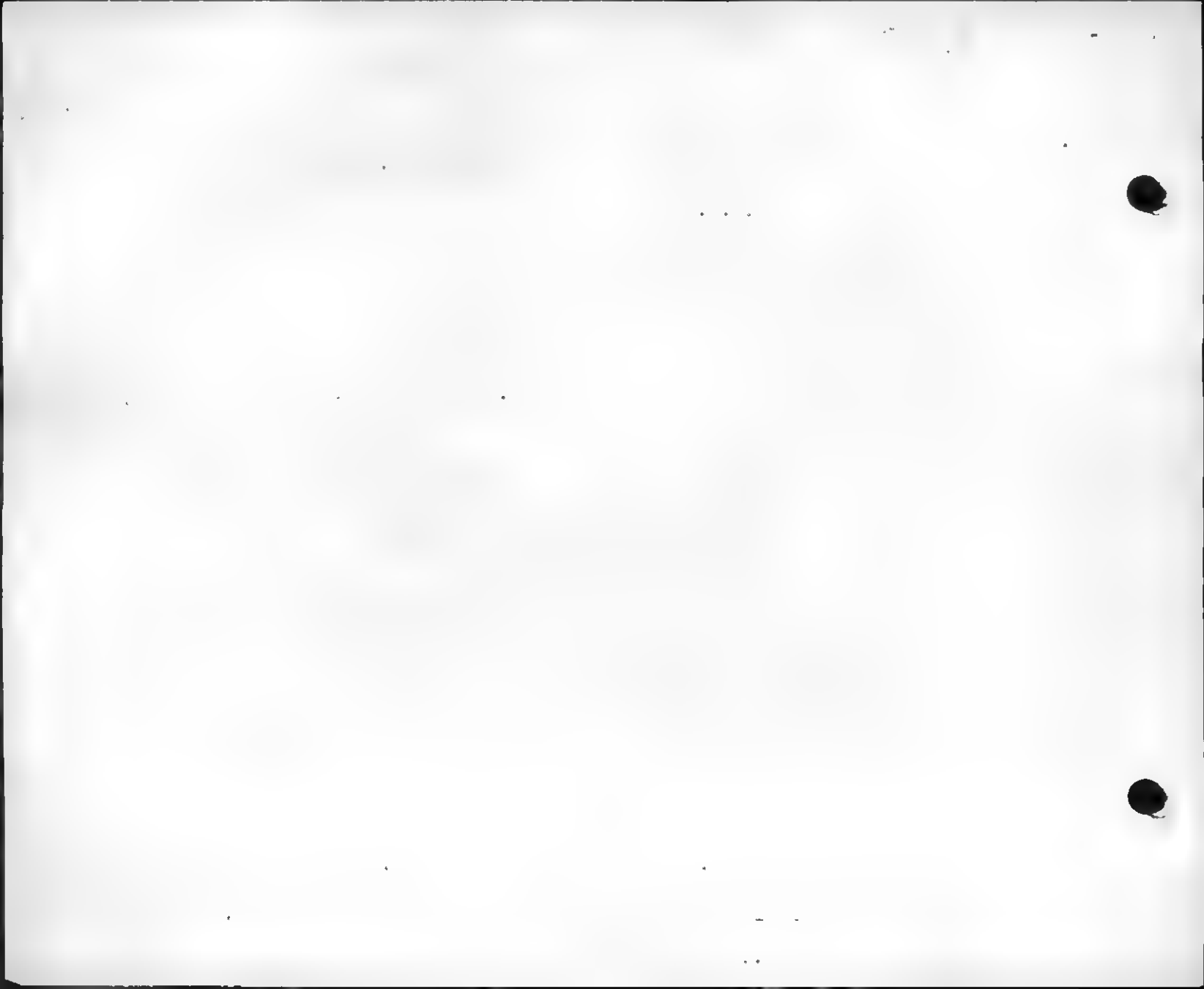
CERTIFICATE OF DEATH

06620

1. DECEASED-NAME (Type or print) DAVID		First Middle Last		2a. DATE OF DEATH Month MAY Day 13 Year 1969		2b. HOUR 7:15 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 25, 1898		6. AGE (In years last birthday) 70 YRS.	
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MILFORD MANOR NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CONTRACTOR		12b. KIND OF BUSINESS OR INDUSTRY BUILDING	
13a. USUAL RESIDENCE (Where deceased lived, if instit. an. Res. dence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last ALFRED POSNER		15. MOTHER'S MAIDEN NAME First Middle Last RAJKA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO		17. INFORMANT MRS. VETTA POSNER, c/o BERNARD POSNER			
				Address 3313 TERRAPIN RD. #2			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate - metastatic 185 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat wh le <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1946 , 19 5/13 , 19 69 , that (I) (we) last saw the deceased alive on 5/13 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hilton B. Kirsh		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/14/69	
22d. PHYSICIAN'S NAME (Type) MILTON B. KIRSH		22e. ADDRESS 4000 W. NORTHERN PKWY.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-15-69		23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR MAY 19 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR AIS 45M - 100

06623		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		06621	
1 DECEASED NAME (Type or print)		First		Middle		Last	
MARX		E		Powell			
3 SEX		4 RACE		5 DATE OF BIRTH		2a DATE OF DEATH	
female		white		9-3-1895		5 Month 1 Day Year 69 9:50 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
md.		U.S.A				Baltimore, Co Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Towson		Chesapeake Manor		Teacher		School	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Baltimore		Towson		2026 Dumont Rd.	
14 FATHER'S NAME		First		Middle		Last	
William		Yates					
15 MOTHER'S MAIDEN NAME		First		Middle		Last	
MARY		I.		Budd			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address	
No		219-25-2135		Mrs Jeanne P. Cumbaa		2026 Dumont Rd	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO OR AS A CONSEQUENCE OF		4-8-69			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		6 Months			
		(c)		1 yr			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 4-8-69, 19 to 5-1, 1969, that (I) (we) lost saw the deceased alive on 5-1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE		22c DATE SIGNED			
22d PHYSICIAN'S NAME (Type)		22e ADDRESS		22f DEGREE		22g ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		5-3-1969		Park Wood Cemetery		Baltimore Maryland	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Wm. Cook-Brooks Towson		1050 York Rd.		MAY 6 1969		John E. Jones	

MEDICAL CERTIFICATION



066224

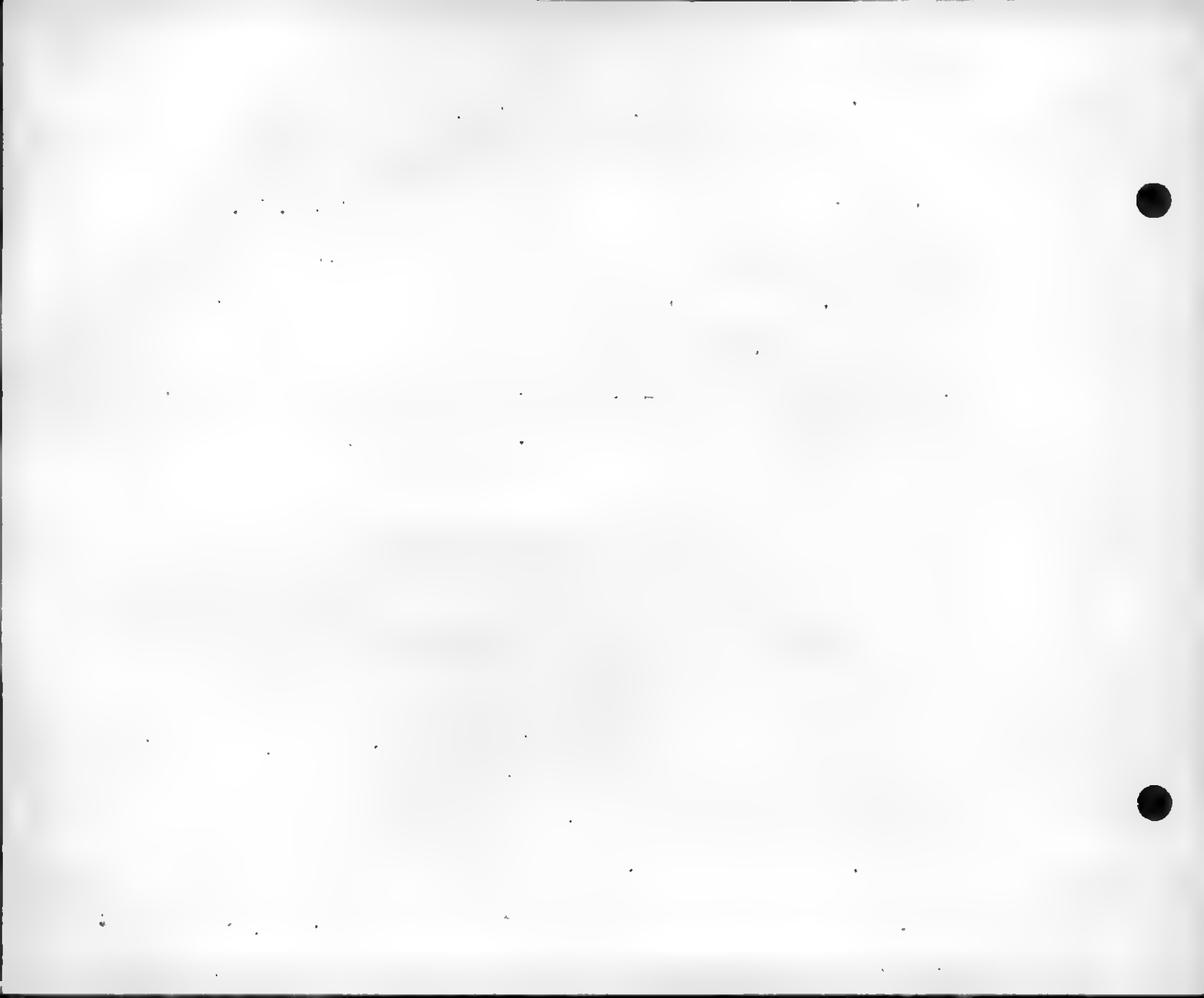
CERTIFICATE OF DEATH

06622

1. DECEASED NAME (Type or print) Mary		First L.		Middle Powers		Last		2a. DATE OF DEATH Month 5 Day 12 Year 69			2b. HOUR 12:20	
3 SEX Female		4 RACE White		5. DATE OF BIRTH 9/23/1887			6 AGE (In years lost birthday) 81 YRS.		IF UNDER YEAR MONTHS 7 DAYS 18		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Balto. Co. Md						
10 CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Stella Maris Hospice			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4022 Roland Ave.		
14. FATHER'S NAME First John Middle Leo Last Livingston			15 MOTHER'S MAIDEN NAME First Mary Middle Agnes Last Forien									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-01-6871			17. INFORMANT Address Stella Maris Hospice Towson Md. 21204						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASCVD - DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from July , 19 68 , to May , 19 69 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE E. Lee Robbins			22c. DATE SIGNED 5/12/69			22d. PHYSICIAN'S NAME (Type) E. Lee Robbins M.D.			22e. ADDRESS 312 Mockingbird Lane			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 5-16-69			23c. NAME OF CEMETERY OR CREMATORY St Joseph's Cmn			23d. LOCATION (City or Town) (County) (State) Texas, Balto Co Md			
24. FUNERAL DIRECTOR Burger Funeral Home Balto Md			25a. REC'D BY REGISTRAR MAY 16 1969			25b. REGISTRAR'S SIGNATURE John Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

06625

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06623

1. DECEASED NAME (Type or print) <i>William</i> First Middle Last		2a. DATE OF DEATH <i>5</i> Month <i>27</i> Day <i>69</i> Year		2b. HOUR <i>11 A</i> M	
3. SEX <i>Male</i>		4. RACE <i>Colored</i>		5. DATE OF BIRTH <i>1/27/95</i>	
7a. BIRTHPLACE (State or foreign country) <i>Albany, N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		6. AGE (in years lost birthday) <i>74</i> YRS.	
10. CITY OR TOWN OF DEATH <i>Mount Wilson</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Mt. Wilson St. Hosp.</i>		9. COUNTY OF DEATH <i>Baltimore County,</i> Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Albany</i>	
14. FATHER'S NAME <i>William</i> First Middle Last		15. MOTHER'S MAIDEN NAME <i>Rola Price</i> First Middle Last		12b. KIND OF BUSINESS OR INDUSTRY <i>Plumber</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-05-0223</i>		17. INFORMANT <i>Records, Mt. Wilson State Hospital</i> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart disease</i> <i>412.3</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic Obstructive Airway disease</i>					
19a. DATE OF OPERATION <i>No</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>12</i> <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>12</i>	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>No</i>		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/21</i> , 19 <i>69</i> , to <i>5/27</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/21</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did)</i> (did not) view the body after death.					
22b. SIGNATURE <i>W. Newcomer</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/27/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>William Newcomer, M.D.</i>		22e. ADDRESS <i>Mount Wilson, Maryland</i>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/31/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>	
24. FUNERAL DIRECTOR <i>William Reese, Jr.</i>		ADDRESS <i>Albany, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

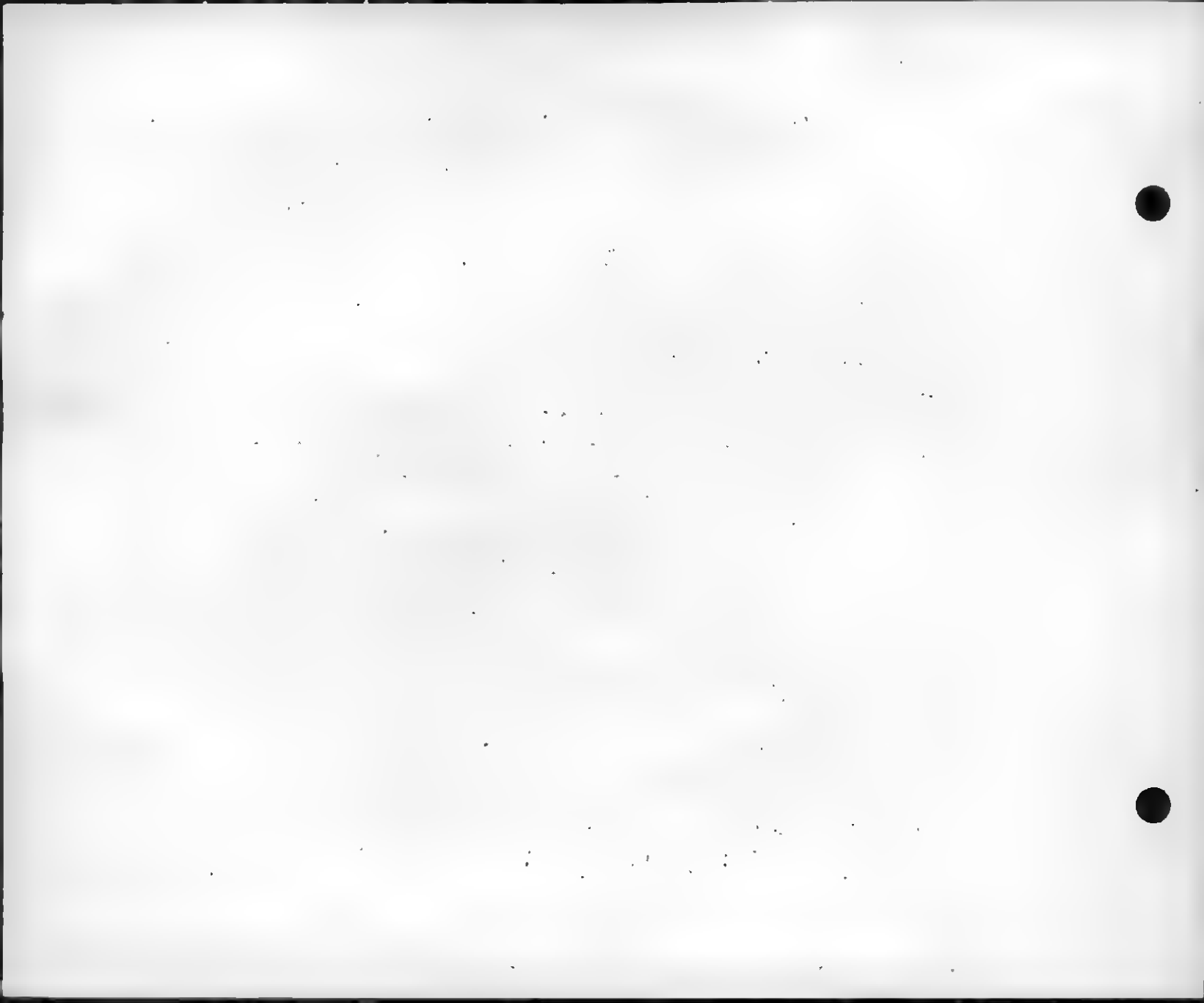


423

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
06626						06624						
1. DECEASED NAME (Type or print) PAULINE POWERS TURYEAR						2a. DATE OF DEATH 5-6-69			2b. HOUR 11:05 AM			
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH Feb 2 - 1881			6. AGE (In years last birthday) 28 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.						
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Towson Convalescent Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if instit. on. Residence before admission) STATE Md			13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1507 LaBelle Ave			
14. FATHER'S NAME First Middle Last Robert W Powers				15. MOTHER'S MAIDEN NAME First Middle Last Juliet Carlton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. -		17. INFORMANT Address H. Young Towson Convalescent Home							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Cerebral and generalized arteriosclerosis												
DUE TO, OR AS A CONSEQUENCE OF Stroke												
(b) _____												
DUE TO, OR AS A CONSEQUENCE OF _____												
(c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (the hospital) attended the deceased from 1940 , 19____, to____, 19____, that (I) (we) last saw the deceased alive on May 6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Louis P. Hamburger Jr. DEGREE MD						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) Louis P. Hamburger Jr.						22e. ADDRESS 1801st Paul St Baltimore Md 21202						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-8-1969		23c. NAME OF CEMETERY OR CREMATORY Hollywood Cemetery			23d. LOCATION (City or Town) Richmond, Virginia		(County) (State)			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. Towson, Md						25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE H. Young				

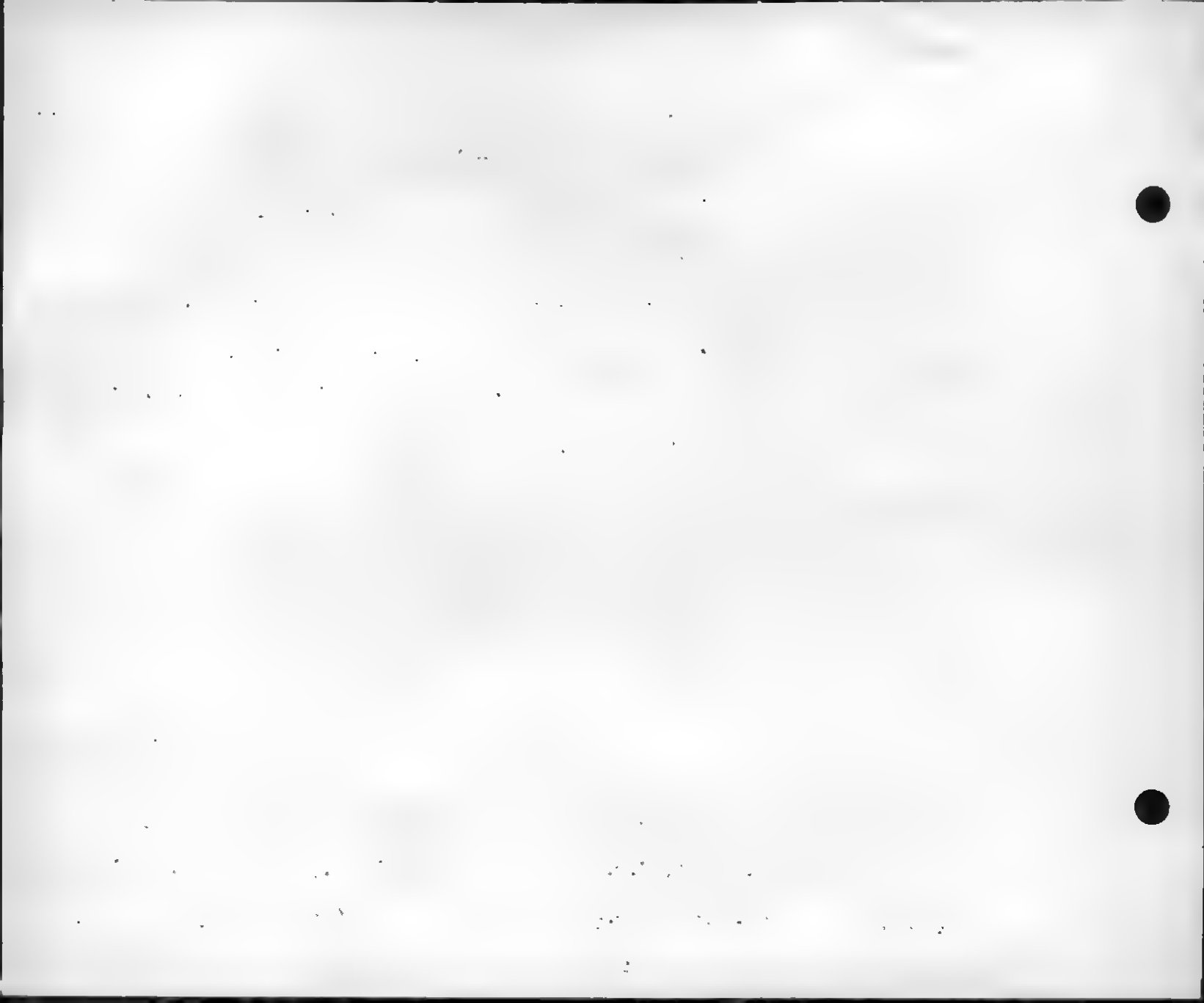


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
OWENS			R.		PYLANT		May			Month 3	Day 1969	5:00 PM
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male			White			3-31-1889			80 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Maryland			USA						Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Towson			St. Joseph's Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			BALTO			ESSEX			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 722, Rt. #1	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
LEVIN T. PYLANT			CORA BENNETT									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
UNK			217-05-5684			MYRTLE PYLANT			ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Cerebrovascular thrombosis												
DUE TO, OR AS A CONSEQUENCE OF												
(b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town County State			
22a. I certify that I (this hospital) attended the deceased from April 29, 1969, to May 3, 1969, that I (we) last saw the deceased alive on May 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED
Elfred A. Quitiquit												5-3-69
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
Elfred Quitiquit, M.D.						7620 York Rd., Towson, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
BURIAL			MAY 6, 1969			WOODLAWN			BALTO. MD.			
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE
J.G. CONNELLY SONS						300 MA CE			MAY 6 1969			Charles Jones



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06628

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06626

1 DECEASED-NAME (Type or Print) George Louis Quelet			2a DATE KNOWN OF ESTI-DEATH MATED 5-28 1969			2b HOUR 8:30 PM		
3 SEX M	4 RACE W	5 DATE OF BIRTH Aug. 1 1906	6 AGE (In years last birthday) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN. 	2c DATE PRONOUNCED DEAD May 28 1969		
7a BIRTHPLACE (State or foreign country) Chattanooga		7b CIT ZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH BALTIMORE			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Belair 21236			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b COUNTY Balto	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 423 Belair Rd 21236		
14 FATHER'S NAME First George Middle L. Last Quelet			15 MOTHER'S MAIDEN NAME First Clemencia Middle Boone Last 					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO 216-05-8203		17. INFORMANT Mrs Elsie G. Quelet			ADDRESS 423 Belair Road 36
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Canceroma of lung. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Atherosclerotic Cardiovascular Disease								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. 		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK HOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State 				
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John C. Hyle			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 5-28-69		
EXAMINER'S NAME (Type) JOHN C. Hyle			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) 7527 Belair Rd		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5-31-1969		23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, City Md.		
24 FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Rd. 21236				25a REC'D BY REGISTRAR JUN 2 1969		25b REGISTRAR'S SIGNATURE Phonias Judge		

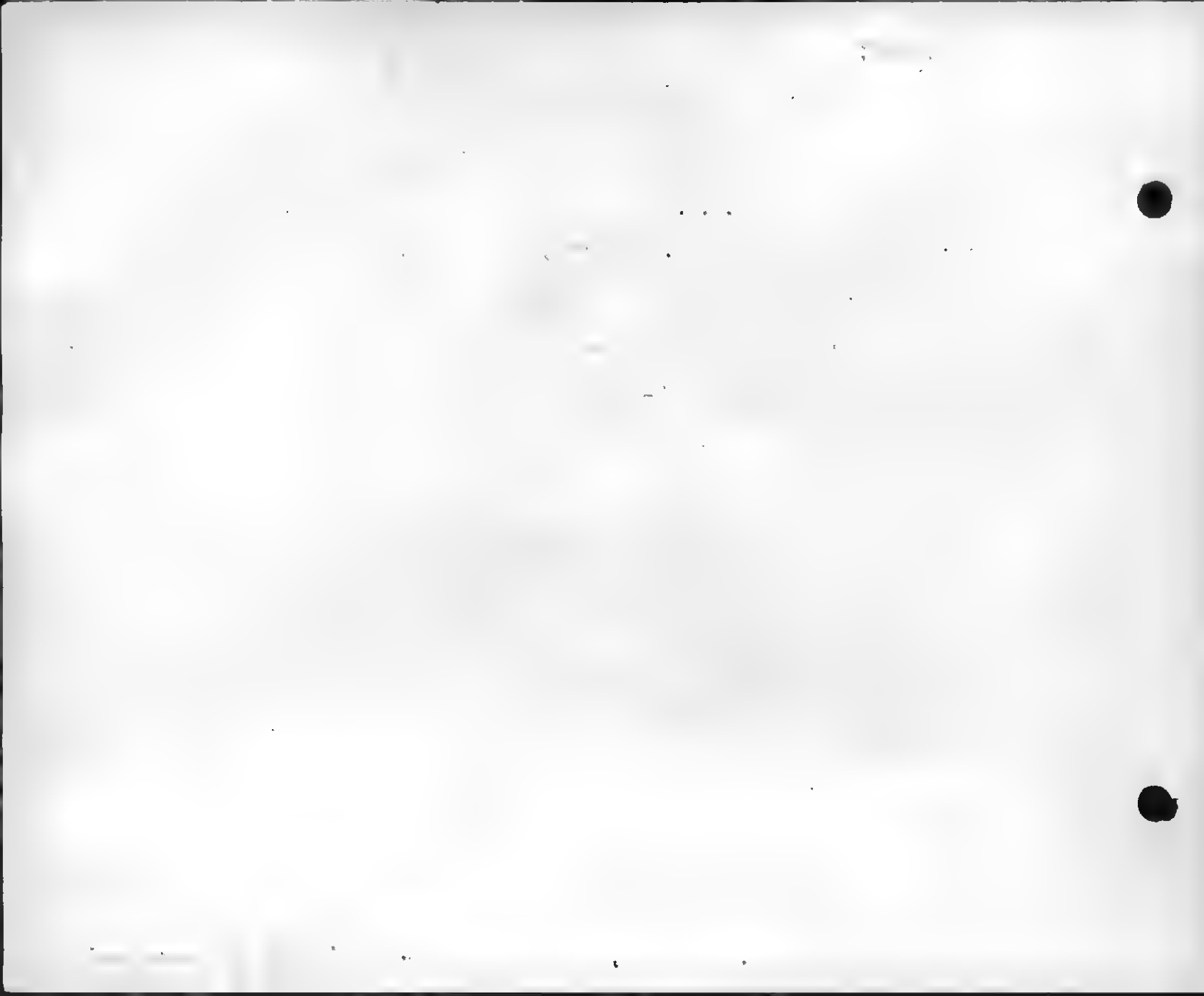


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If the funeral director removes carbon papers, page 3 should be detached for use as the burial-transit permit, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.)

1978

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR
JOSEPH NMN RAGNO						Mon 05 Day 20 Year 69			6:20 am
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
MALE		CAU		April 4, 1895			7 YRS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			10
Italy		U.S.A.				BALTIMORE			Md.
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give address)			12a-USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
BALTIMORE			GREATER BALTO., MED. CEN.			Retired Stone Mason			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			13b COUNTY		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2705 Ailsa Ave
14 FATHER'S NAME			15 MOTHER'S M A D E N NAME			16			17
First Middle Last			First Middle Last						
Joseph Ragno			Angela Miano						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT			Address	
No			217-03-7416		Mrs Josephine Ragno			Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LIVER WITH									
DUE TO, OR AS A CONSEQUENCE OF									
CONDITIONS if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			P.M. 19						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5/4 1969, to 5/20 1969, that (I) (we) last saw the deceased alive on 5/20 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE						22c DATE SIGNED			
George Pikler, M.D.						5/20/69			
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS			
GEORGE PIKLER, MD									
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial			5/24/69		Holy Redeemer		Baltimore, Maryland		
24 FUNERAL DIRECTOR						25a REC'D BY REG. STRAR		25b REGISTRAR'S SIGNATURE	
Leonard J Ruck Inc. Baltimore, Maryland						DATE MAY 21 1969		John Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

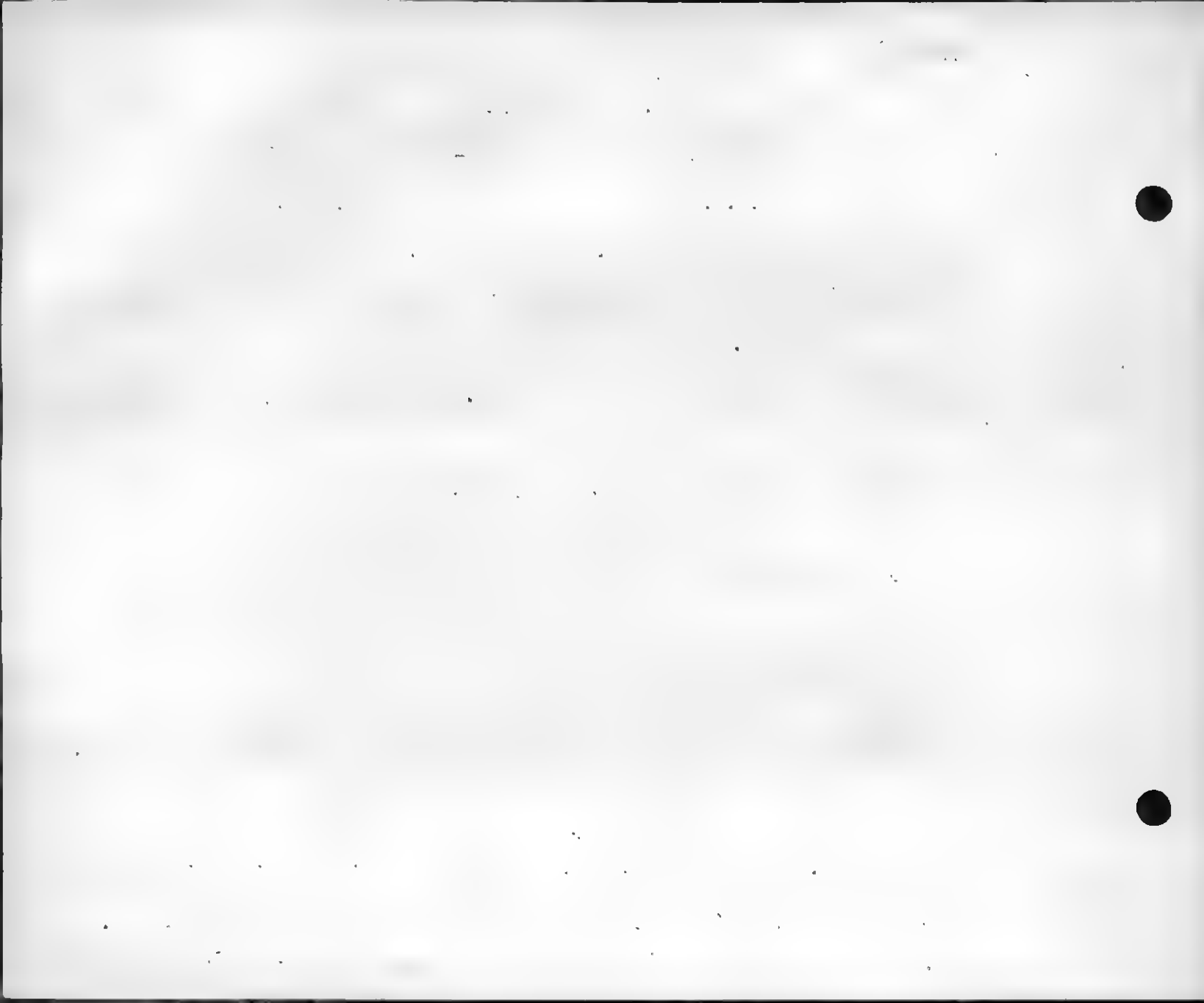
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06630

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06628

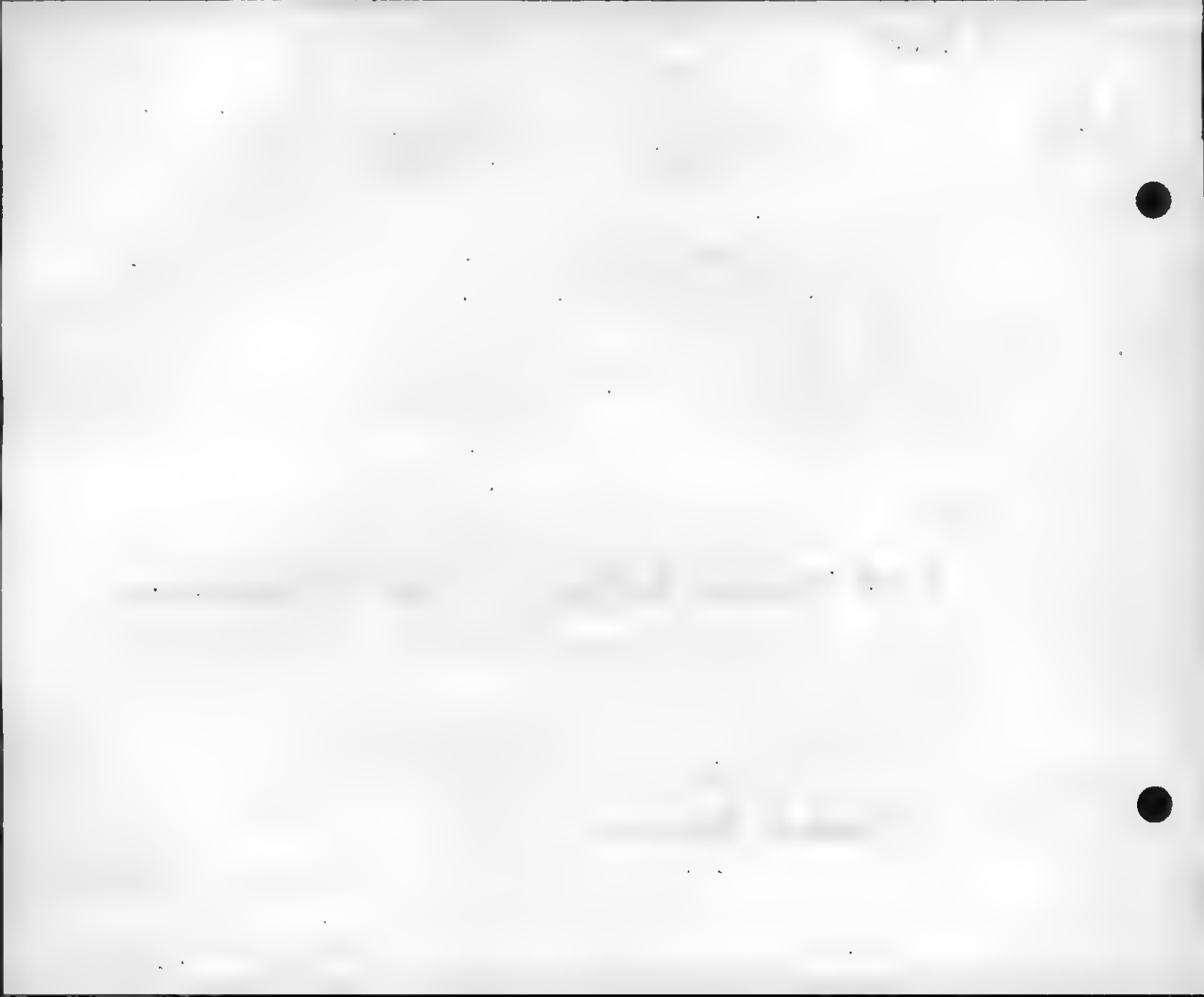
1. DECEASED NAME (Type or print) EDITH L. RAYMO			2a. DATE OF DEATH May Month 18 Day 1969 Year		2b. HOUR 1:00AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 1-4-1898		6. AGE (In years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIM. IS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4231 Berger Avenue	
14. FATHER'S NAME First Middle Last MAJOR JENKINS		15. MOTHER'S MAIDEN NAME First Middle Last MARY GELLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address CHAS. RAYMO 4231 BERGER AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 1125 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 7 , 19 69 , to May 18 , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 18 , 19 69 , and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE Jaime B. Punzalan			DEGREE MD.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED May 18, 1969
22d. PHYSICIAN'S NAME (Type) Dr. Jaime Punzalan, M.D.			22e. ADDRESS 7620 York Road Towson, Md. 21204		
23a. BURIAL, CREMATION, REMOVA. (Specify) BURIAL	23b. DATE 5/21/69	23c. NAME OF CEMETERY OR CREMATORY MORFAND MEMORIAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST.			25a. REC'D BY REGISTRAR MAY 22 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06631					06629					
1. DECEASED-NAME (Type or print) First Middle Last John T. Redman					2a. DATE OF DEATH 5 Month 29 Day 69 Year					2b. HOUR 5:50 M
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH Nov 4, 1911		6. AGE (In years lost birthday) 57 YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore,		Md.		
10 CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Stone Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY L MITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 10911 York Rd.	
14. FATHER'S NAME First Middle Last Issac E. Redman					15. MOTHER'S MAIDEN NAME First Middle Last Lily May Justice					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO. W W Two 215-07-6468		17. INFORMANT Address Mrs. Blanche Ayres, Belfast Rd. Sparks, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) <u>Arteriosclerotic cardiovascular disease</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>SEVERE PULMONARY EMPHYSEMA - SMALL PULMONARY EMBOLI</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>5/21/</u> , 19 <u>69</u> , to <u>5/29</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/29</u> a.m. 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death										
22b. SIGNATURE <u>Charles C. Brown, M.D.</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/29/69		
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M.D.						22e. ADDRESS 6701 N. Charles St. Balto., Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE June 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial			23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson,						ADDRESS 1050 York Road Towson, Md. 21204		25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06632

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06630

1. DECEASED-NAME (Type at print) First Middle Last Mamie B. Reinhardt			2a. DATE OF DEATH Month Day Year May 26 1969			2b. HOUR M	
3 SEX Female		4 RACE white		5 DATE OF BIRTH Sept. 13, 1884		6 AGE (In years last birthday) 84 YRS.	
7a BIRTH-PLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Cockeysville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Md. masonic Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Store	
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. ✓		13b COUNTY —		13c CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last David Summers		15 MOTHER'S MAIDEN NAME First Middle Last Julia W. Wilson.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b SOCIAL SECURITY NO 215-10-7166A		17 INFORMANT Address Records of Md. masonic Home's			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4104 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) Cardinals, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 10 yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from May 13, 1969, to May 26, 1969, that (I) (we) last saw the deceased alive on May 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Carl F. Benson				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/26/69	
22d. PHYSICIAN'S NAME (Type) Carl F. Benson				22e. ADDRESS 5111 York Rd Baltimore Md 21212			
23a BURIAL, CREMATON, REMOVAL (Specify) Burial		23b DATE 5-29-1969		23c NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Road 21204				25a REC'D BY REGISTRAR MAY 27 1969		25b REGISTRAR'S SIGNATURE James J. Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

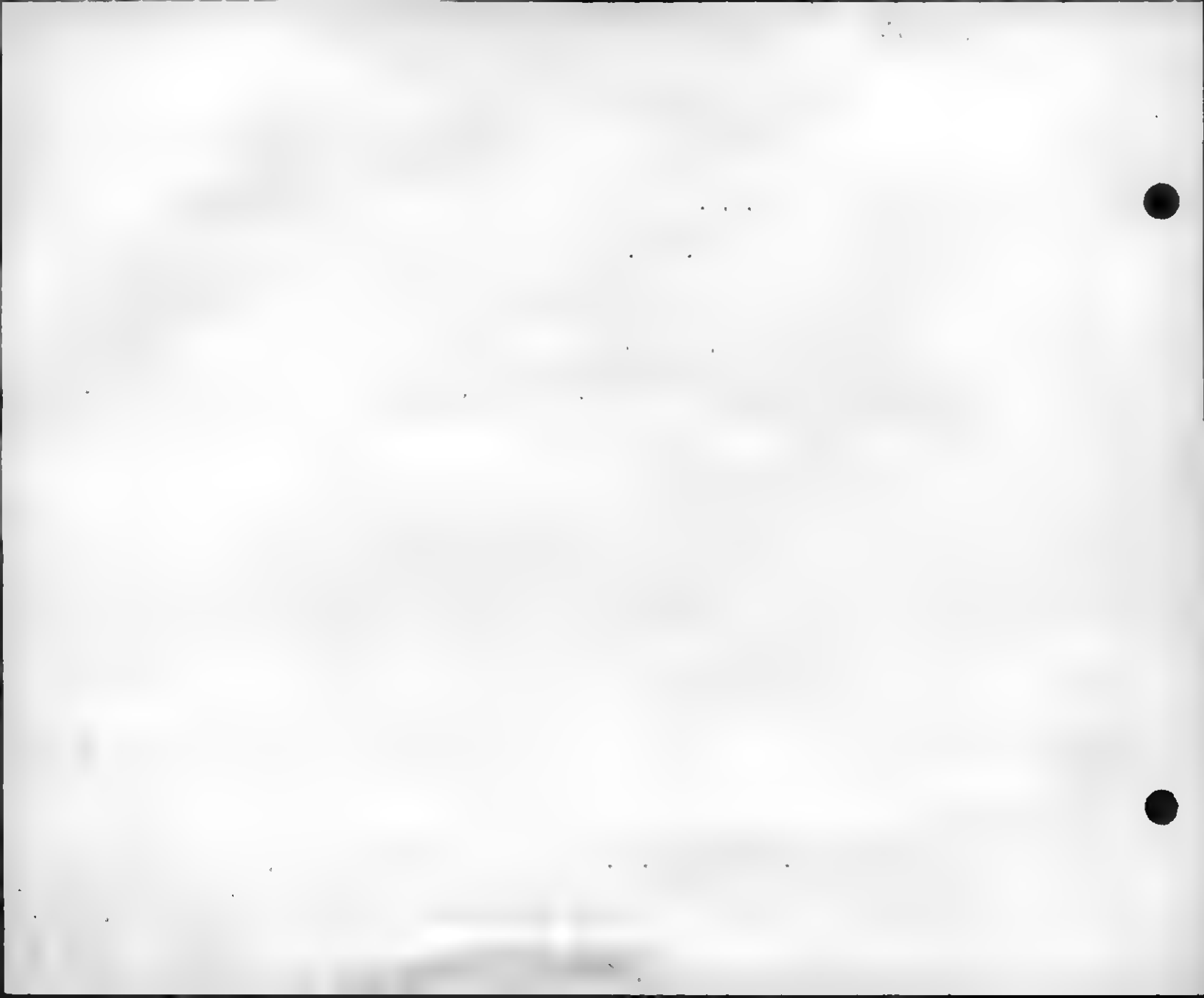
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED		2b. HOUR	
DOROTHY MARGARET			RICE			5-15-69		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD	
F	W	Sept 21 1883	85 YRS					May 25 1969	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY	
New York		USA				Baltimore		M	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Parkton			Elder Ave			Housewife			
13a USUAL RESIDENCE (Where deceased lived, if institution, Res. den. before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md			Baltimore			Parkton			
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Albert F Heinze			Margaret						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT ADDRESS			
No						Hammill A Rice 21222 7434 School Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C. & G. Disease</u>									
4124 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Pulmonary edema</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>G.M. France</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) <u>R. M. FRANCE</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			5/25/69			
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			5/28/69		Woodlawn		Baltimore Co Md		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Burgess Funeral Home			Baltimore Md			MAY 29 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, register and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06634		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06632	
Item #1 Film #G413 6/2/69 vpw					
1 DECEASED NAME (Type or print)		First Middle Last		2a. DATE OF DEATH	
STANLEY (James) JOSEPH		RICE		5 Month 22 Day 6 Year 6:45P M	
3 SEX		4 RACE		5 DATE OF BIRTH	
MALE		WHITE		12/22/32	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		6 AGE (In years last birthday)	
MARYLAND		U.S.A.		36 YRS.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10 CITY OR TOWN OF DEATH	
		BALTIMORE COUNTY		FORT HOWARD	
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
VET. ADM. HOSPITAL		CLERK		POST OFFICE	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND				BALTIMORE	
14 FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)	
JAMES J. RICE		JENNIE ZADERNOWSKI		YES PL 28	
16b. SOCIAL SECURITY NO		17 INFORMANT Address		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))	
218 28 82 28		CLIN. RECORDS, VA HOSP. FT HOWARD, MD.		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA	
571.9		DUE TO, OR AS A CONSEQUENCE OF		(b) CIRRHOSIS OF LIVER	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from 4/17/69, 19 to 5/22/69, 19, that (h) (we) last saw the deceased alive on 5/22/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (h) (we) (did) (did not) view the body after death.		22b. SIGNATURE	
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
5/23/69		JOHN D. TALBERT, M. D.		VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, ETC. (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		5-27-69		LOUDEN PARK NATIONAL CEMETERY	
23d. LOCATION (City or Town) (County) (State)		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
BALTIMORE, MD.		MAY 26 1969		John M. Webster, Registrar	
24. FUNERAL DIRECTOR ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
John M. Webster, Registrar		MAY 26 1969		John M. Webster, Registrar	

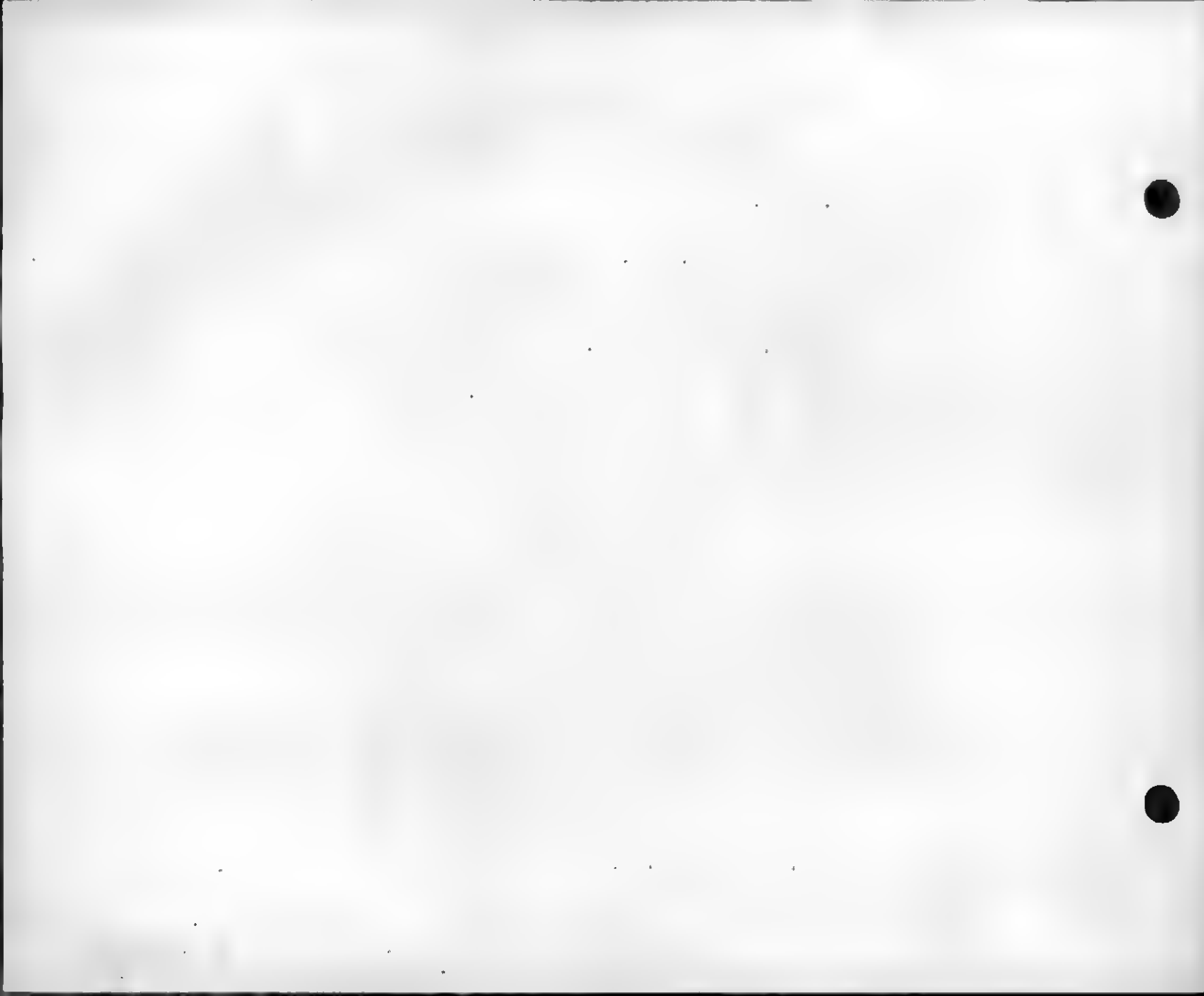


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VR A 45M 69

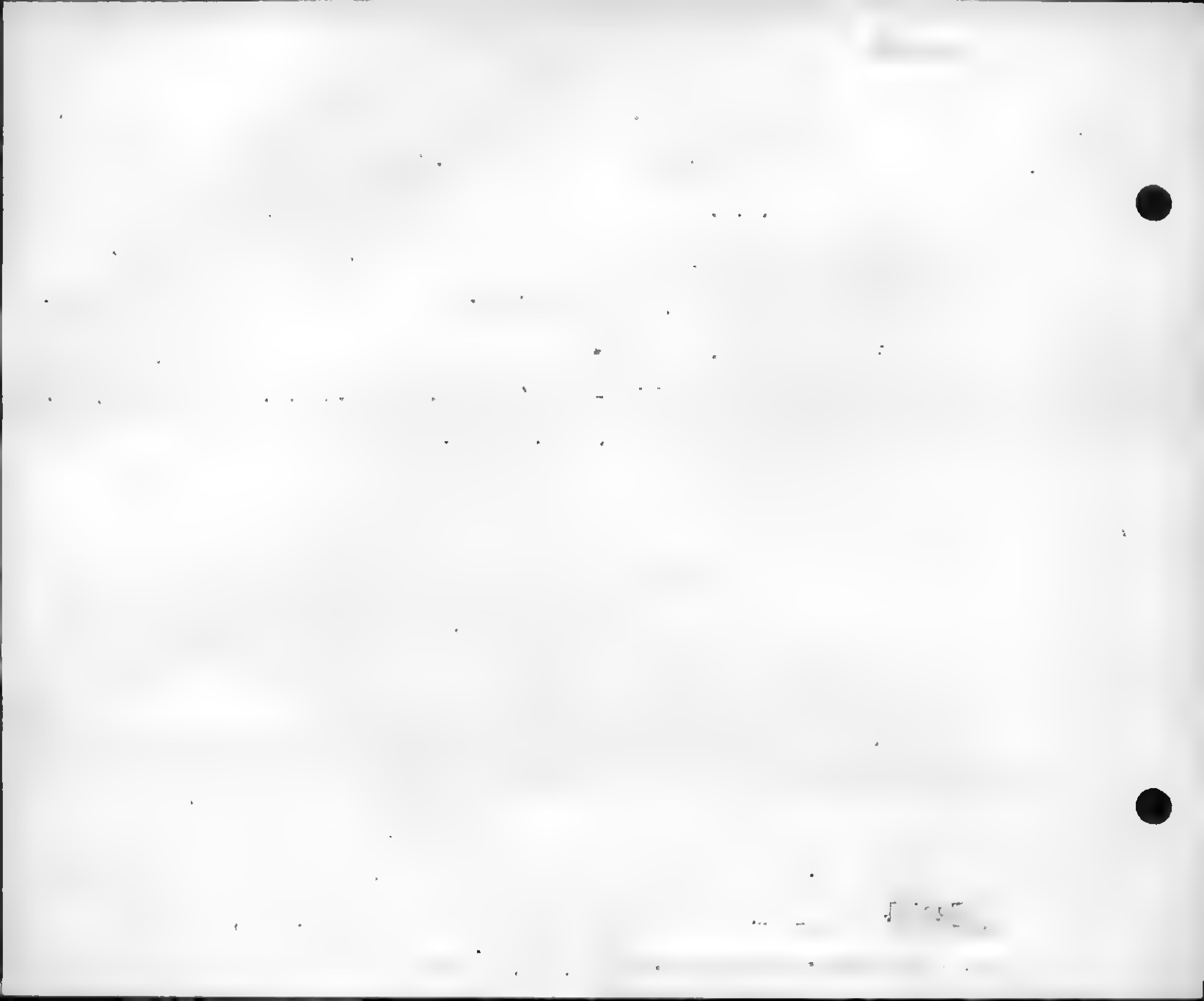
06635		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06633	
Item 23b File # 13 6/3/69kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH
ARTHUR		S.		RICHMOND, JR.	Month 5 Day 23 Year 69 8:35AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (n years last birthday)	IF UNDER 1 YEAR MONTHS DAYS
MALE	WHITE	1/30/15		54 YRS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
BALTIMORE, MD.		U.S.A.		9. COUNTY OF DEATH BALTIMORE COUNTY, Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
FORT HOWARD		VET. ADM. HOSPITAL		FLORIST MAYFIELD CO.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		-		BALTIMORE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
First Middle Last		First Middle Last		13e. STREET AND NUMBER	
ARTHUR S. RICHMOND, SR.		ROBERTA MITCHELL		4402 Shamrock Rd. Balto.Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address	
YES WW II		215 28 97 24		CLIN. RECORDS, VA HOSP. FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG					
1621 DUE TO, OR AS A CONSEQUENCE OF CHRONIC BRONCHITIS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5/22/69, 19, to 5/23/69, 19, that (I) (we) last saw the deceased alive on 5/23/69, 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
JOHN D. TALBERT, M. D.				5/23/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS	
JOHN D. TALBERT, M. D.				VAH FORT HOWARD, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		5/27/1969		BALTIMORE NATIONAL	
24. FUNERAL DIRECTOR		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JOHNSON FUNERAL HOME		M.D. 28 1969		[Signature]	
8521 LOCH RAVEN BLVD.		BALTIMORE, MD.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Milton M. Roberts						2a. DATE OF DEATH Month Day Year 5 7 69			2b. HOUR 9:55PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5-22-82			6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Lithographer			12b. KIND OF BUSINESS OR INDUSTRY Metal			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. den. before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5920 Falkirk Road, 21212				
14. FATHER'S NAME First Middle Last Edward J. Roberts				15. MOTHER'S MAIDEN NAME First Middle Last ? ? Bird								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 215-367-6056		17. INFORMANT Address Oscar C. Roberts R.D.#1 Boyertown, Pa.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary emboli												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from April 24, 1969 , to May 7, 1969 , that (I) (we) last saw the deceased alive on May 7, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE William M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (Type) Dr. Thos. M. D.						22e. ADDRESS 760 York Rd. Towson Md. 21204						
23a. BURIAL (CREMATON, etc.) 5-10-69		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR Mr. Cook-Brooks Towson, Inc.						ADDRESS 1050 York Rd. Towson, Md. 21204		25a. REC'D BY REGISTRAR MAY 12 1969		25b. REGISTRAR'S SIGNATURE		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

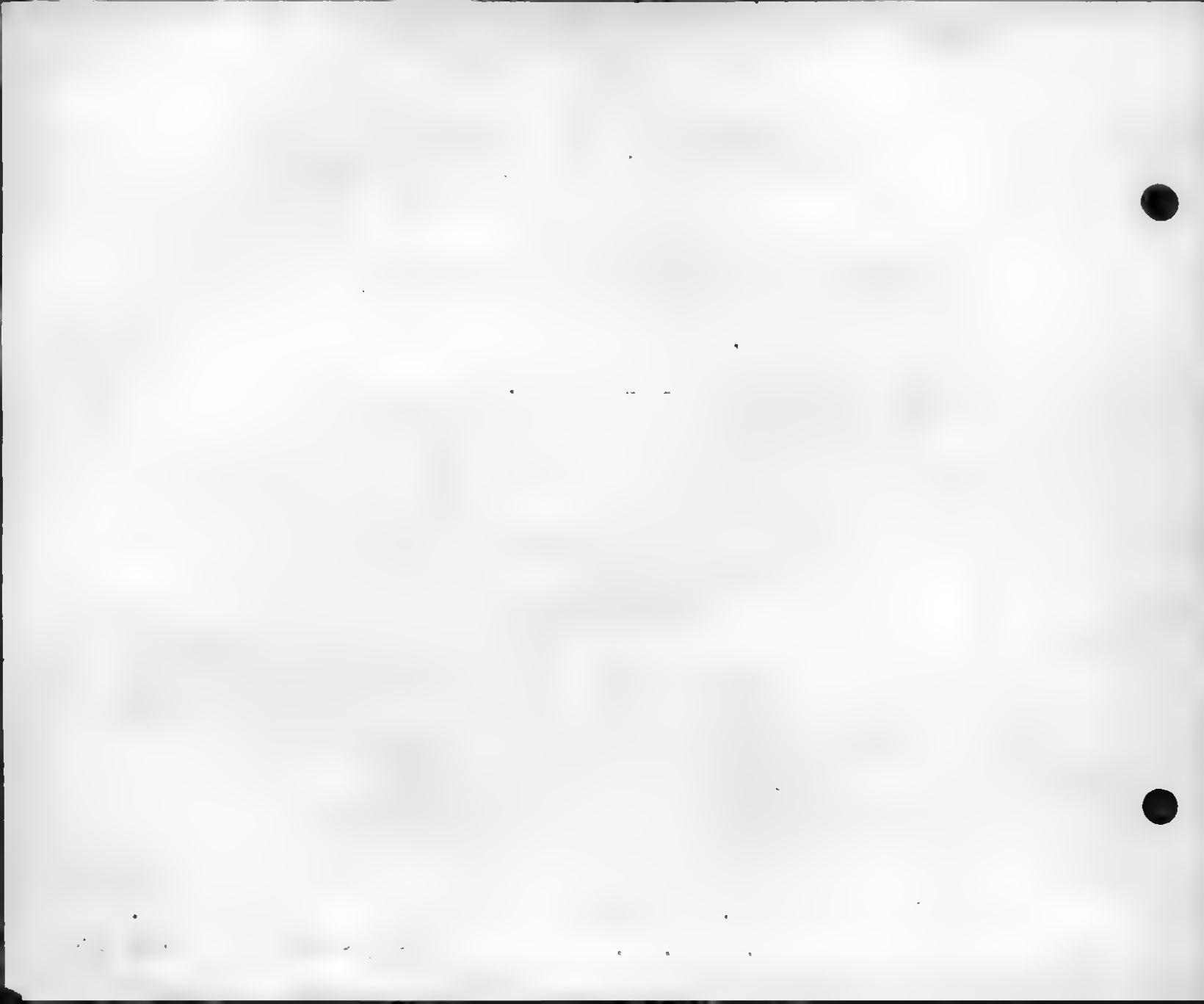
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06637

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06635

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/>			Month	Day	Year	2b. HOUR
SUSAN			LEE			RUPERT			19			
3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (n years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR	
female	white	July 17, 1946.	22					May 26, 1969			1:45 A.M.	
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Cntr.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Beautician			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Baltimore			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER 1209 Walker Avenue
14. FATHER'S NAME First Middle Last Chauncey B. Showalter			15. MOTHER'S MAIDEN NAME First Middle Last Ruth Maddocks									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 219-44-8920			17. INFORMANT Mr. Chauncey Showalter			ADDRESS (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR AM 12:28 PM 5/26/69			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Passenger in car which was involved in head- on collision with another car						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) street			21f LOCATION Street or RFD No City or Town County State Belair Rd. near Chapel Road, Maryland						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Werner U. Spitz, M.D.						22b DATE SIGNED 5/26/69			
23a BURIAL, CREMATION REMOVAL (specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			5/29/69.			Gardens of Faith Cemetery			Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR MAY 28 1969			25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-14
30M REV. 1/68

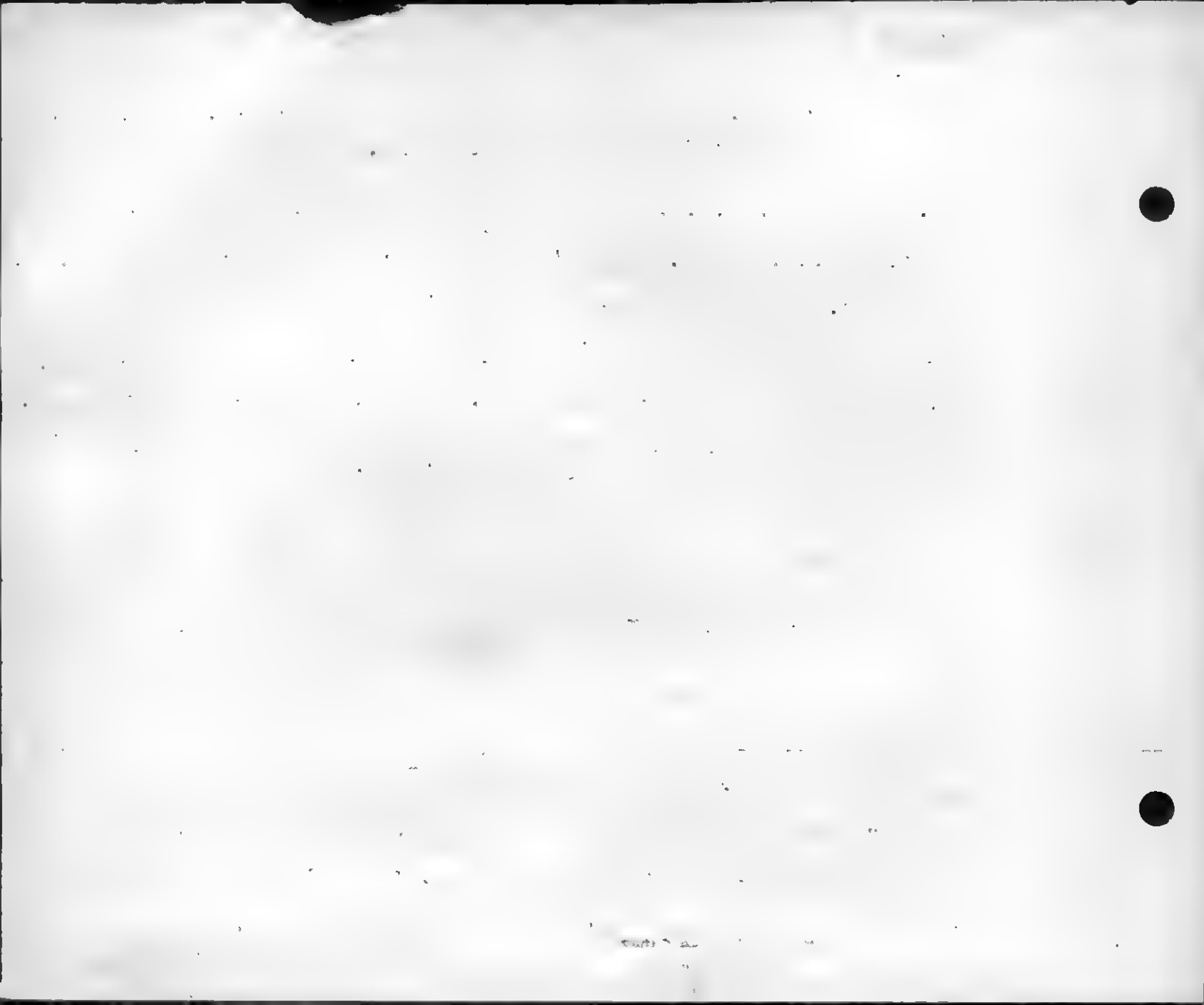
06638

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06636

1 DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
John M. Russell				May 18, 1969		12:15	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Male	White	March 12, 1986		83			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
St. Mary's City	U.S.A.			Baltimore County Md			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville, Md.	St. Joseph's Nursing Home		Civil Engineer		Balto. Cit		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER			
Md.	Baltimore	Catonsville		103 Melvin Avenue			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		Address			
Charles Russell		Adrianna Dawson		Catonsville			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT				
No		217-38-2034	Mrs. Mary A. Senner-103 Melvin Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>							8 months +
DUE TO, OR AS A CONSEQUENCE OF (b) <u>with impaired circulation to legs.</u>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3-28-69		Amputation of leg.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 11, 1968, to May 18, 1969, that (I) (we) last saw the deceased alive on May 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John A. Nesbitt, Jr.				22c. DATE SIGNED 5-19-69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
John A. Nesbitt, Jr.				1009 Frederick Road			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5/21/69	New Cathedral Cemetery - Balto., Md.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Sterling Funeral Establishment 736 Edmondson Ave. Catonsville, Md. 21228		MAY 22 1969		Charles Judge			

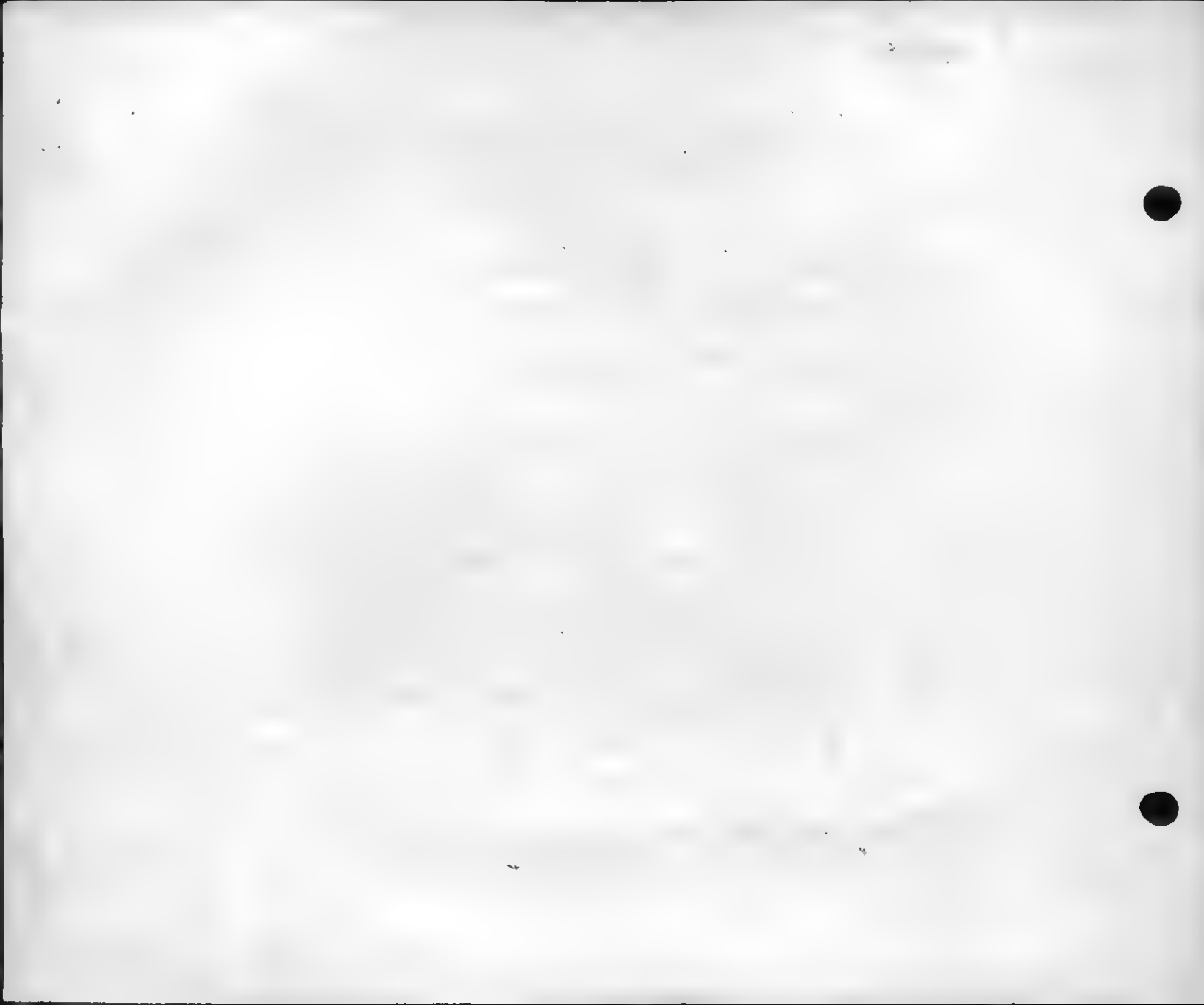


**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR	
EDNA		E.		SACHS				MAY 6 1969		1208	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD	2d. HOUR		
F	W	3/21/96	73 YRS					Month MAY Day 6 Year 1969	78		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY			
MD.		USA				BALTO					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					
DUNDALK			781 OAKLEIGH RD								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MD.			BALTO		DUNDALK				701 OAKLEIGH RD		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
WILLIAM EROMAN			P								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			
UNK					RUTH HIBBARD			ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V Disease</u>											
4124 DUE TO, OR AS A CONSEQUENCE OF											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
			None								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)						
			19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			M.B. DAVIS M.D. - 6800 Maryland Ave. - Dundalk			DEPT. MEDICAL EXAMINER			6/7/69		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
BURIAL			5/9/69		DAK LAWN			BALTO. MD.			
24. FUNERAL DIRECTOR					ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE
J.G. CONNELLY SONS					300 MACE			MAY 9 1969			John J. Connelly



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06640

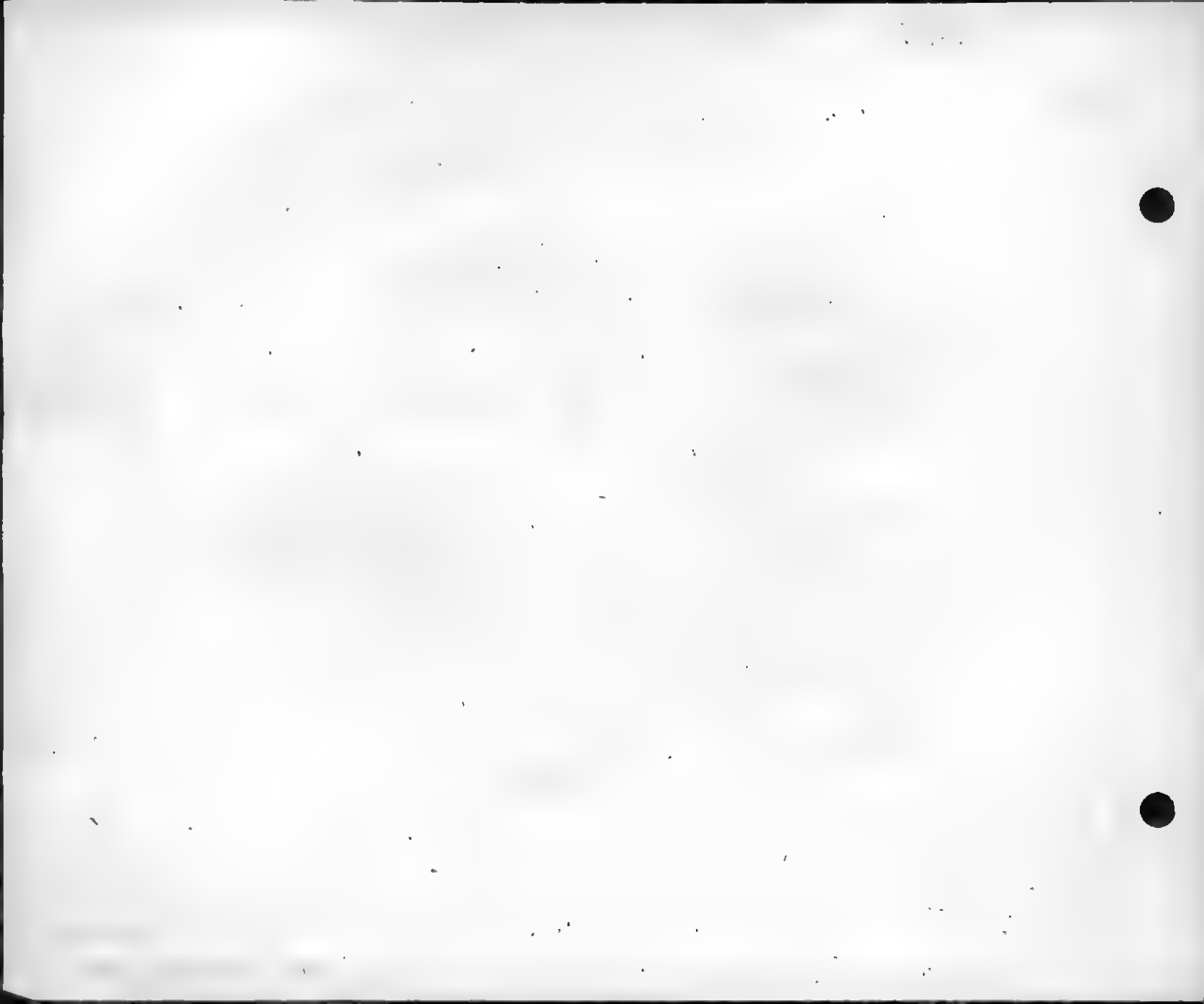
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film 413 6/4/69 mk

CERTIFICATE OF DEATH

06638

1. DECEASED NAME (Type or print) John Albert Schaefer		2a. DATE OF DEATH May Month 15 Day 1969 Year		2b. HOUR 8:45 M
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH OCT 9 1905	6 AGE (In years last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) BALTO MD	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTO. Md	
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2816 GARNET Rd.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE md.	13b. COUNTY BALTO	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2816 GARNET Rd.
14 FATHER'S NAME First Middle Last John Schaefer		15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Loeffler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO 705-07-2311	17 INFORMANT Address Mrs John Schaefer		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary insufficiency 41- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years 4 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from April 7, 1969 , to May 15, 1969 , that (I) (we) last saw the deceased alive on April 7, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Ronald Jandorf		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 5-15-69	
22d. PHYSICIAN'S NAME (Type) R Donald Jandorf		22e. ADDRESS 7403 Hartford Rd		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 5/19/69	23c. NAME OF CEMETERY OR CREMATORY Louisa Park	23d. LOCATION (City or Town) (County) (State) BALTO MD	
24. FUNERAL DIRECTOR Wm J Tickner & Sons		25a. REC'D BY REGISTRAR MAY 22 1969	25b. REGISTRAR'S SIGNATURE Charles Judge	

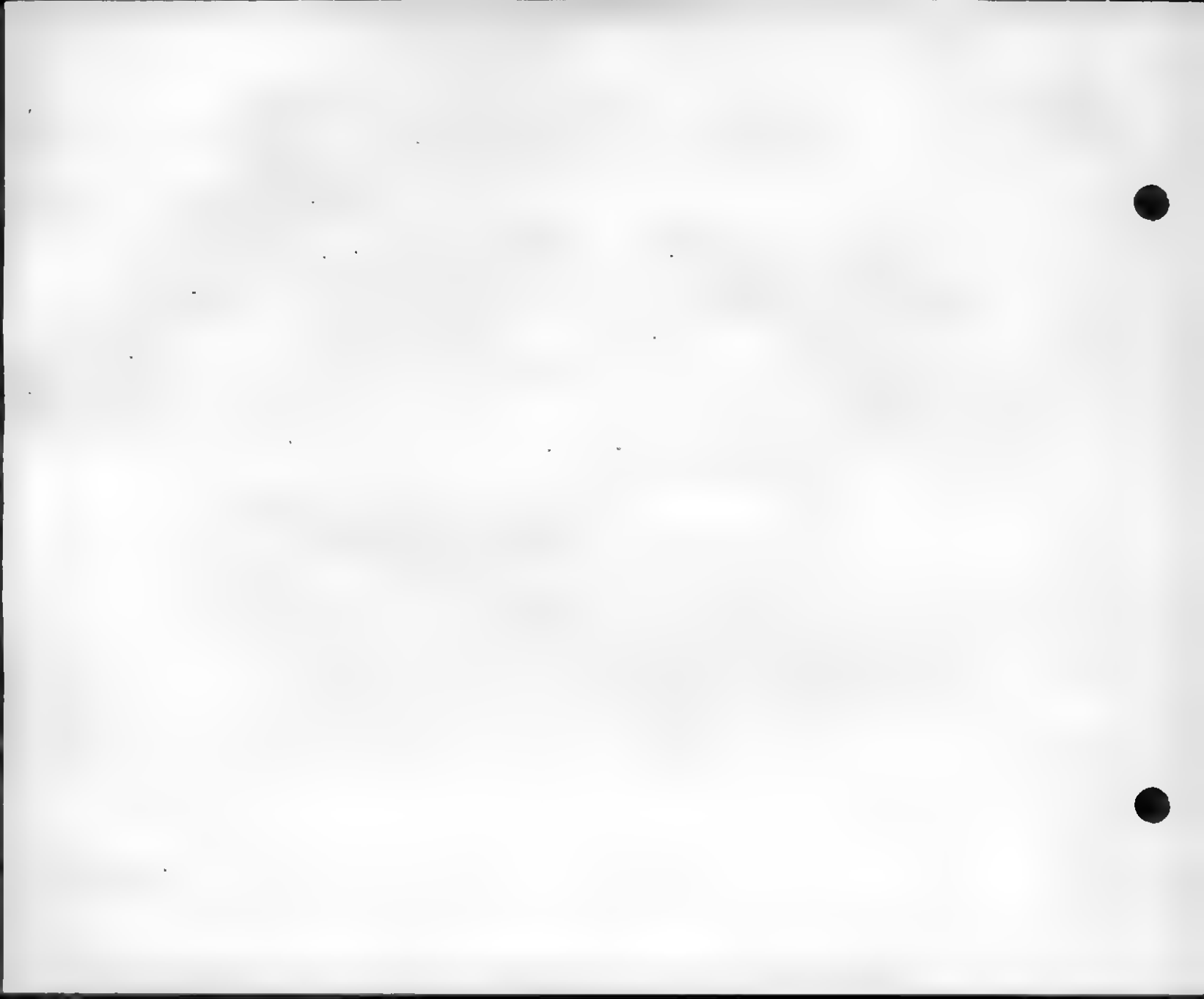


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 407-2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Gerard William Schuch						May 2, 1969		1:06 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		white		12-3-1903		65		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore		USA				Towson Baltimore		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph Hospital		Retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2420 Wellbridge Dr. 21234	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Peter Schuch			Franzicka Lynch						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
		212-05-3828		Donald A. Schuch, son,		21224 1521 Elrino St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS UNDERLYING: IMMEDIATE CAUSE (a) <u>Ruptured aortic arteriosclerotic aneurysm.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
May 2, 1969		Leaking abdominal aneurysm.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (X) (this hospital) attended the deceased from May 2, 1969, to May 2, 1969, that (X) (we) lost the deceased alive on May 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Christina Feliciano, M.D.</i>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED May 2, 1969	
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D.						22e. ADDRESS 7620 York Road, Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/6/69		Parkwood Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane						25a. REC'D BY REGISTRAR MAY 7 1969		25b. REGISTRAR'S SIGNATURE	



1579

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>			c. LENGTH OF STAY IN lb <u>LIFE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3100 EAST AVE</u>					d. STREET ADDRESS <u>3100 EAST AVE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Schulte</u> Last <u>Schulte</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1969</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-8-1897</u>		9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months <u></u> Days <u></u> IF UNDER 24 HRS: Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Stone Mason</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND - BALTO.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Henry Schulte</u>					14. MOTHER'S MAIDEN NAME <u>Kunigumba Ollrich</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW I</u>			16. SOCIAL SECURITY NO. <u>218-03-8565</u>		17. INFORMANT <u>Ann Schulte</u>			Address <u>Same</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u> <u>metastases to liver and</u> <u>ascites</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>61</u> to <u>May</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 19 1969</u> , and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Frank T. Kasik</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/19/69</u>			
22c. PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK</u>					22d. ADDRESS <u>9005 HARTFORD RD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-22-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Lm</u>			23d. LOCATION (City, town or county) (State) <u>Parkville MD</u>			
24. FUNERAL DIRECTOR <u>CHAS. F. EVANS & SON</u>					ADDRESS <u>8802 HARTFORD RD</u>		25a. REC'D BY REGISTRAR <u>MAY 21 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Schulman</u>	

Handwritten text, possibly a signature or name, located in the upper left quadrant of the page.

Handwritten text, possibly a signature or name, located in the lower right quadrant of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

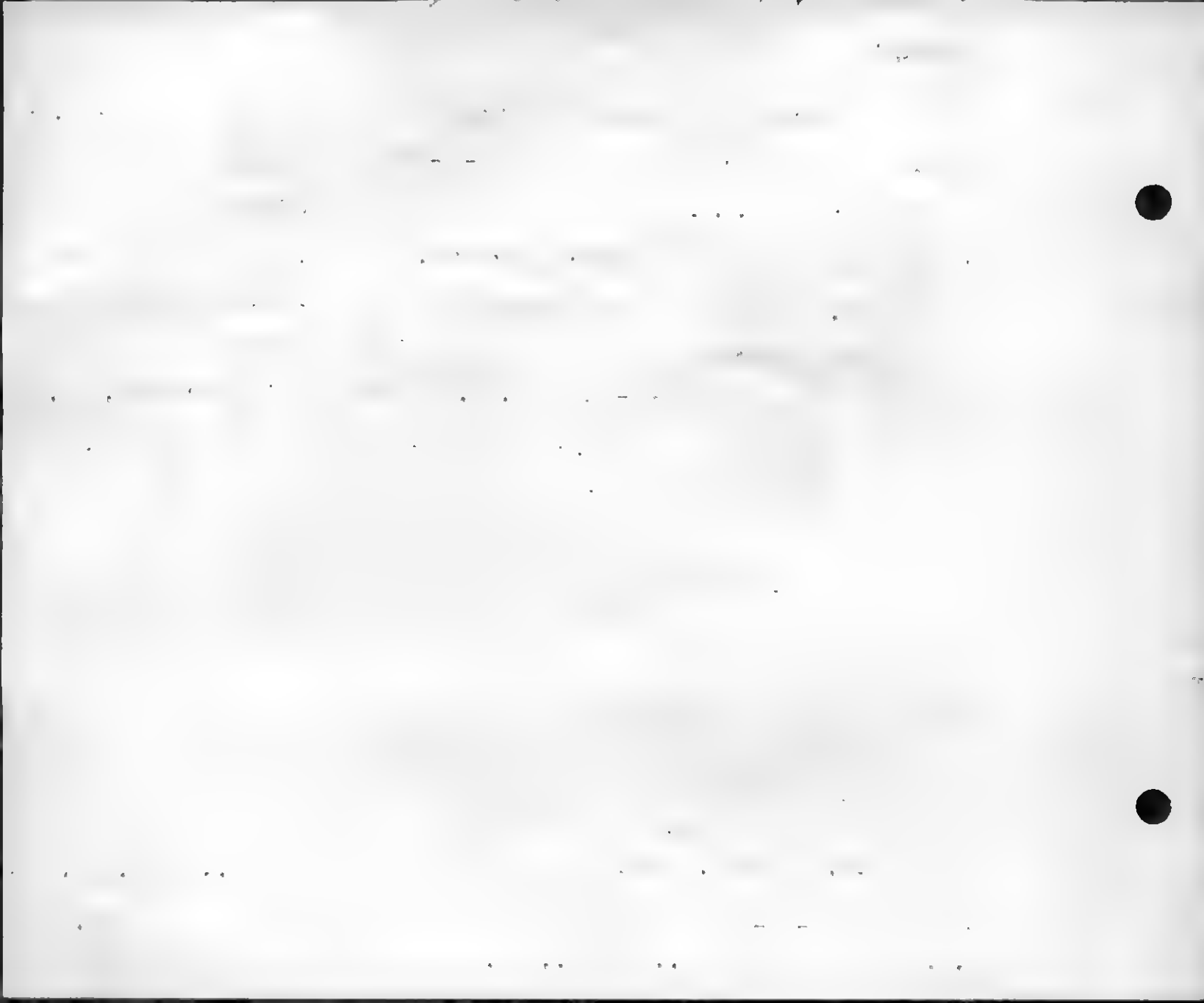
1

06643

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06641

1. DECEASED-NAME (Type or print) Sarah Elizabeth Schumacher			2a. DATE OF DEATH Month 5 Day 17 Year 1969			2b. HOUR 5.45 A.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 12-25-1886		6. AGE (In years last birthday) 82 YRS	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) College Manor Inc.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First George Middle Schumacher Last Schumacher		15. MOTHER'S MAIDEN NAME First Mary Ann Middle Markland Last Markland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give year or dates of service)		16b. SOCIAL SECURITY NO 220-44-0425		17. INFORMANT S. M. Edward		Address Lutherville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4107 (b) arteriosclerosis C-V disease DUE TO, OR AS A CONSEQUENCE OF (c) Cholelithiasis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Immediate							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cholelithiasis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 1964 to May 17, 1964 , that (I) (see) last saw the deceased alive on May 15, 1964 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.							
22b. SIGNATURE A. Allan Spier				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/19/64	
22d. PHYSICIAN'S NAME (Type) Dr. Allan A. Spier				22e. ADDRESS 1501 Pentridge Rd., Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-20-69		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Balto Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co., Balto., Md.				25a. REC'D BY REGISTRAR DATE MAY 19 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

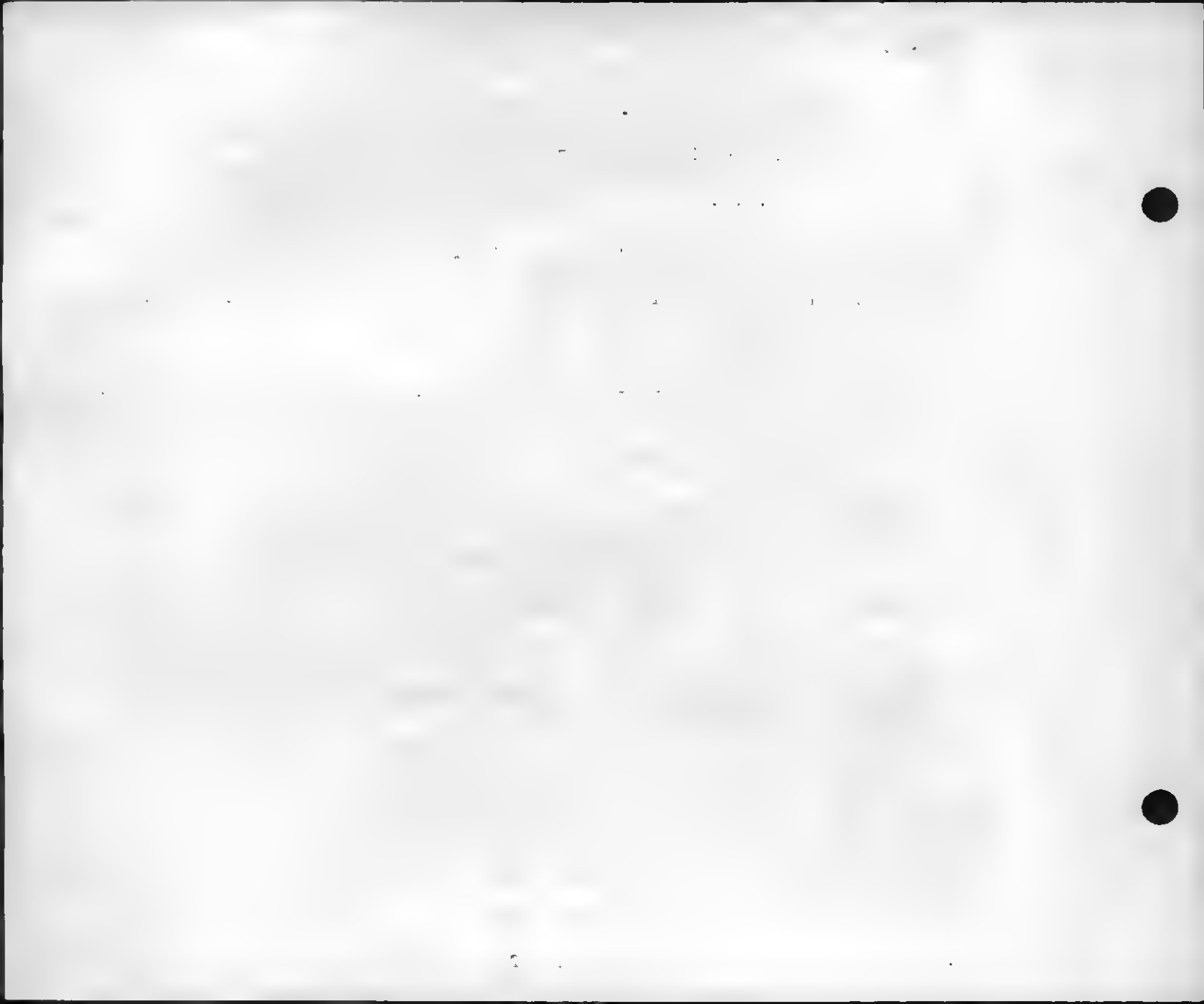
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06644

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06642

1. DECEASED-NAME (Type or Print) MICHEAL E. SCHWARTZ			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year May 14 1969			2b. HOUR 7:58 M			
3. SEX M	4. RACE CAU	5. DATE OF BIRTH 5-18-1921	6. AGE (In years last birthday) 48 1/2 YRS	7. UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	8. UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD May 14 1969			2d. HOUR 7:58 M
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) GREATER BALTO. MED. CEN.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) School teacher		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1018 Jamieson Road 21093	
14. FATHER'S NAME Andrew Skvore			15. MOTHER'S MAIDEN NAME Helen Kovarc						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO 288-16-9803		17. INFORMANT Mrs. Ruth C. Schwartz ADDRESS 1018 Jamieson Rd. 21093				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Coronary Insufficiency (b) 5+ yrs DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles F. O'Donnell			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 5/14/69			
23a. BURIAL CREMATION, REMOVAL (Specify) Cremation			23b. DATE 5-17-1969		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson				ADDRESS 1050 York Rd. 21204		25a. REC'D BY REGISTRAR MAY 16 1969		25b. REGISTRAR'S SIGNATURE James J. Ye	

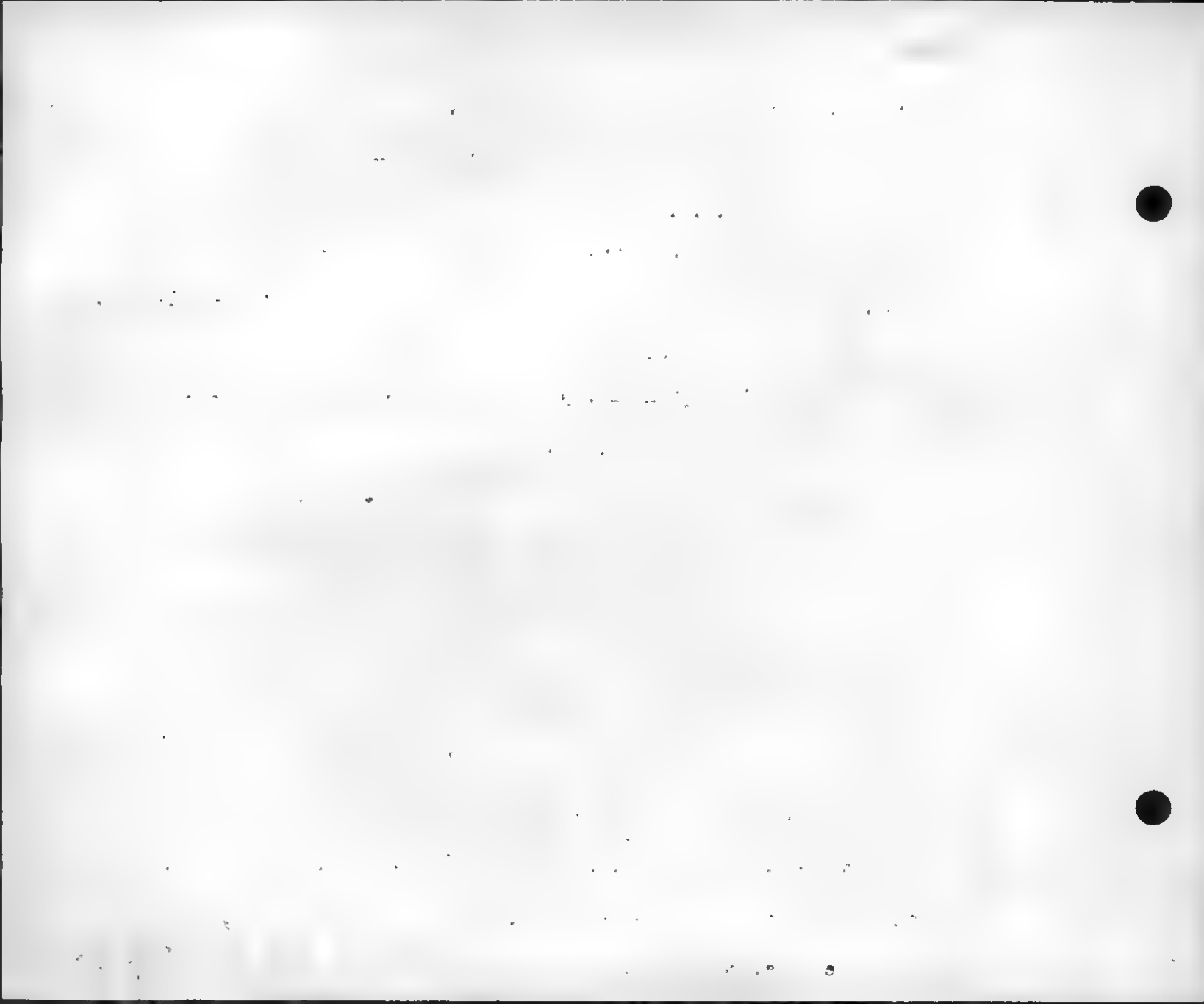


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) (Joseph) GUISEPPI			First Middle Last SCILIPOTI			2a. DATE OF DEATH Month Day Year May 30 1969		2b. HOUR AM PM 5:05 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12-14-1896 95		6. AGE (In years last birthday) 73 YRS		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2814 Glendale Ave. 21234	
14. FATHER'S NAME First Middle Last Thomas Scilipoti			15. MOTHER'S MAIDEN NAME First Middle Last Josephine ? ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 216-01-7740		17. INFORMANT Mrs. Santa Scilipoti		Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Intractable Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio-vascular Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 25, 1969 , to May 30, 1969 , that (I) (we) last saw the deceased alive on May 30, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jaime M. Punzalan		22c. DATE SIGNED 5-30-69		22d. PHYSICIAN'S NAME (Type) Jaime M. Punzalan, M.D.					
22e. ADDRESS 7620 York Rd., Towson, Md. 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/2/69		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Leonard J Ruek Inc. Baltimore, Maryland				25a. REC'D BY REGISTRAR DATE JUN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE FILM 413 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			Month	Day	Year	2b HOUR
PERLEY ALLEN SCOTT						5 17 19 69			12	pm		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR	
Male	White	4/22/1923	46 YRS	MONTHS	DAYS	HOURS	MIN.	May 17 19 69			12p M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH						
Ya.		U.S.A.				Balto.			Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Balto.			516 N. Rolling Rd.			CICRR			GROCERY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			
Md.			Balto.			Balto.			YES <input type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO			
George Washington Scott			LULA MAC			Yes			218-18-0818			
17 INFORMANT			18 ADDRESS			19			20			
Shirley Gray			2120 Frederick Rd			21228						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease												
4124 DUE TO, OR AS A CONSEQUENCE OF (b) complicated by acute ethylism												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?						
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			19 P M									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b DATE SIGNED			
Ronald N. Kornblum, M.D.						May 18, 1969						
EXAMINER'S NAME (Type)			23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			
			Burial			5/21/69			BALTIMORE NATIONAL CEM.			
									BALTIMORE Md			
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE						
E.S. MacNabb			301 Frederick Rd			May 21 1969			Orlando Judge			
			Balto Md 21228									

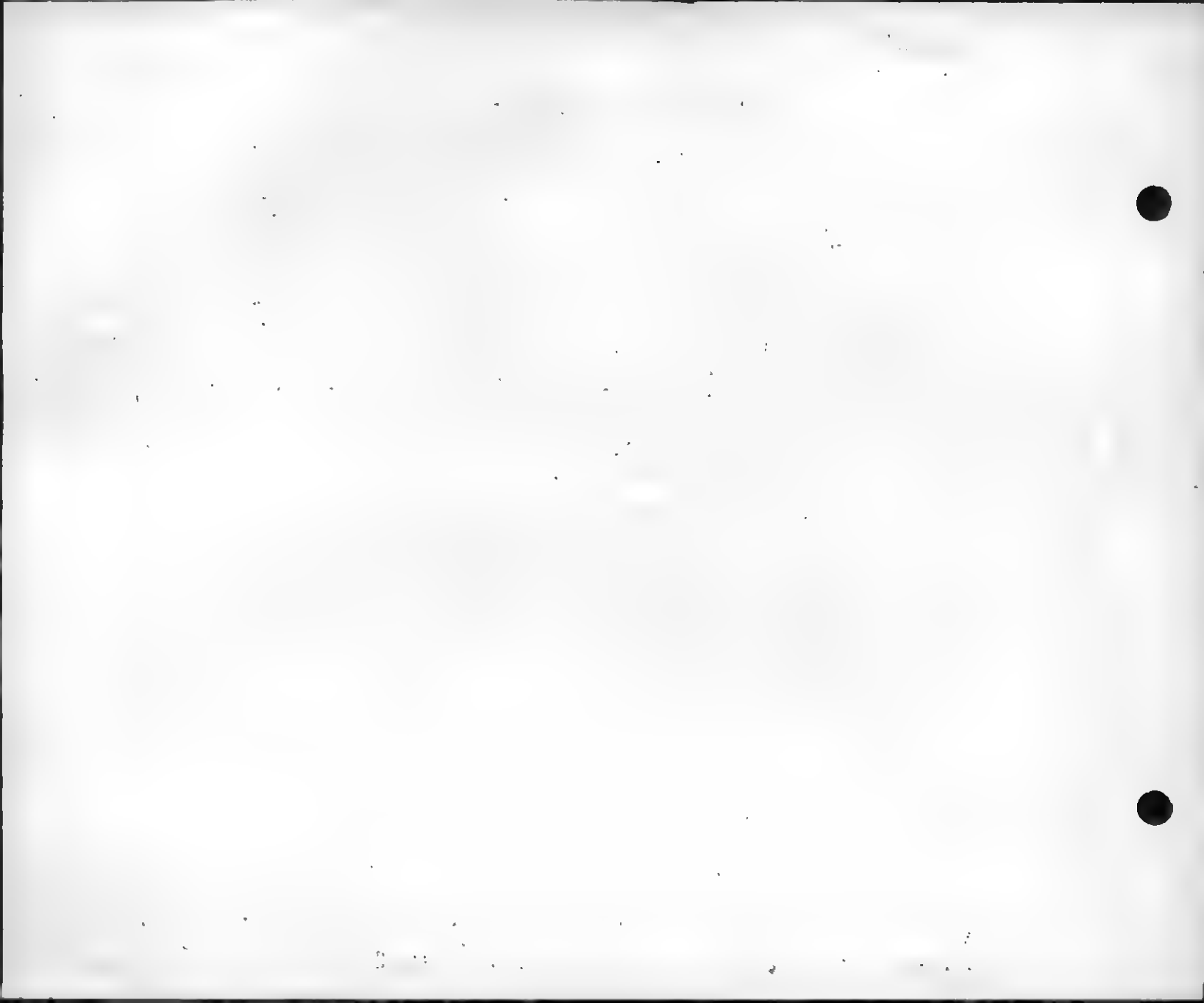


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
06645											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Charles L. Shaffer						May 17 1969			7:00 AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		Cauc.		April 9, 1908		67 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
Md.		U.S.A.		WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Parkton			Armaccost Rd			Laborer			Balto City		
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b COUNTY			13c STREET AND NUMBER					
Md.			Balto			Parkton			Armaccost Rd.		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Wm Henry Shaffer			Mary Ellen Basehore								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			218-38-3749			Mrs. Anna Shaffer			Armaccost Rd, Parkton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year								
			P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION			Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 1940, to 5/17, 1969, that (I) (we) last saw the deceased alive on 5/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
A. M. France			5/17/69								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
A. M. FRANCE			PARKTON, Md.								
23a. BURIAL, CREMATION, or other disposal (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			5/19/69			Pine Grove Cem. -			Parkton, Balto. Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
James Hartenstein, New Freedom, Pa.			MAY 21 1969			Charles Judge					

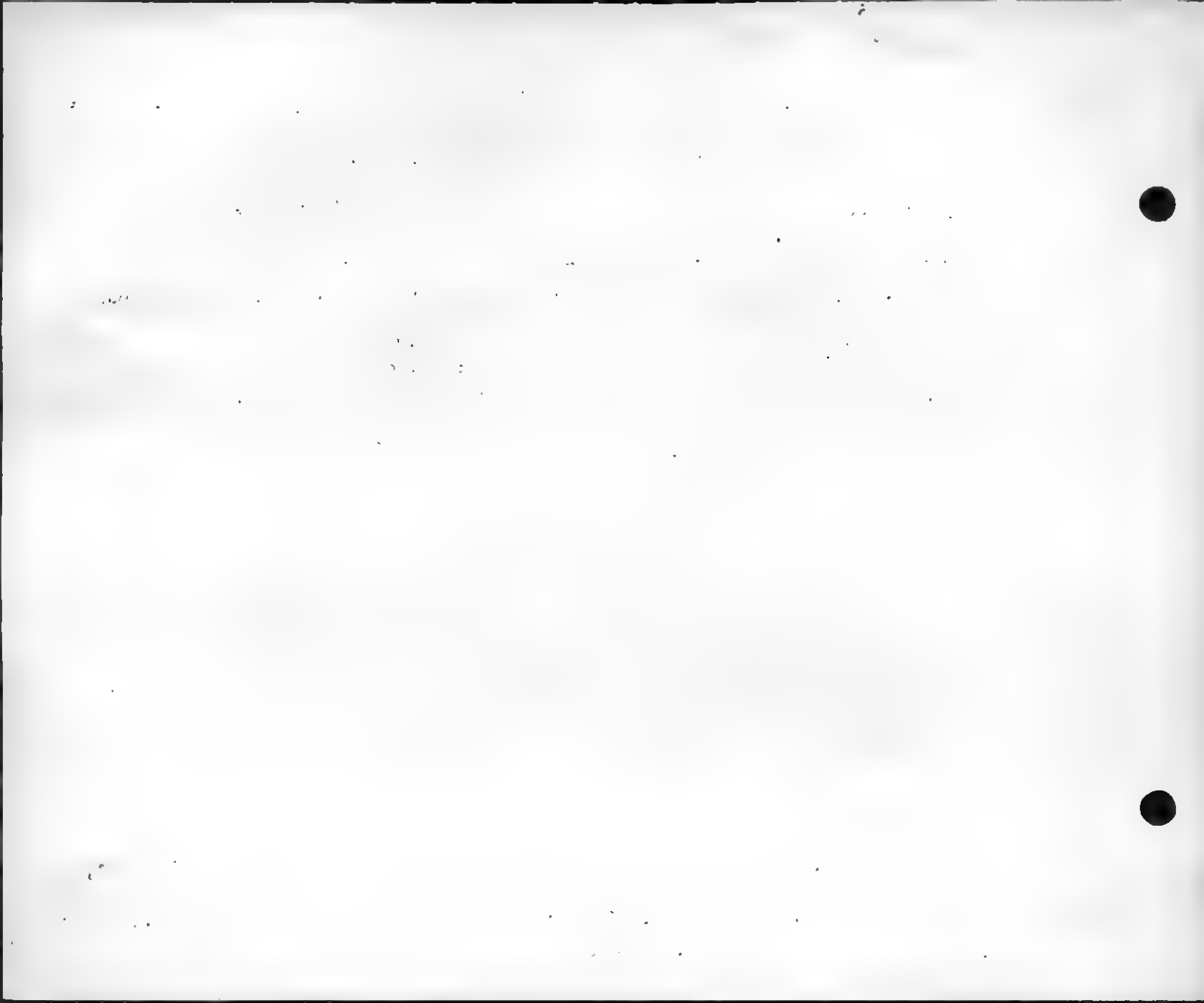


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-68)
30M REV 7-68

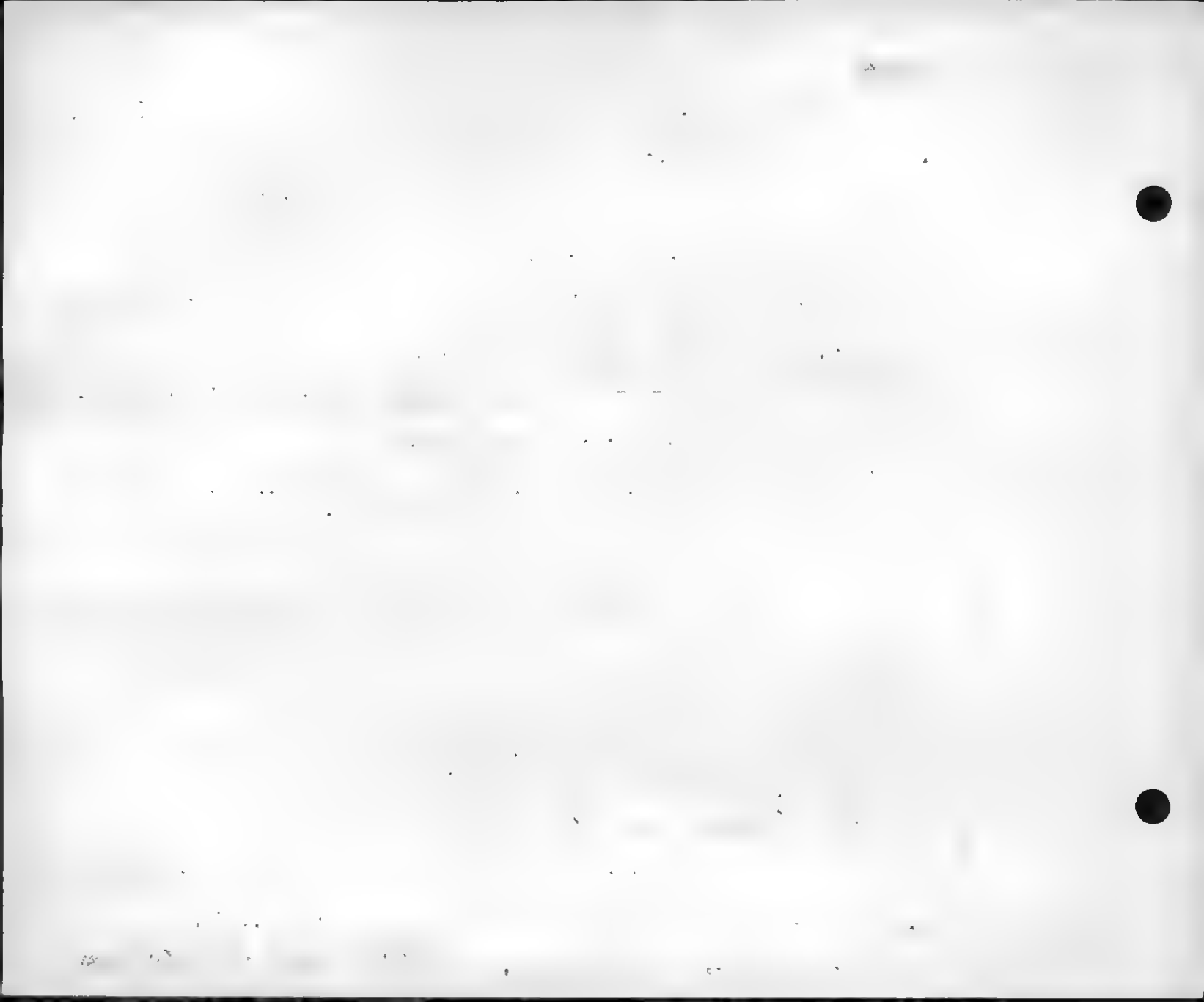
<div style="display: flex; justify-content: space-between;"> 06648 MARYLAND STATE DEPARTMENT OF HEALTH 06646 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. DECEASED NAME (Type or print) ^{First} ^{Middle} ^{Last} Mary GRACE SHANNON						2a. DATE OF DEATH Month Day Year May 2, 1969			2b. HOUR 5:15 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 30, 1876			6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS M.M.
7a. BIRTHPLACE (State or foreign country) Hartf. Co., Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.					
10. CITY OR TOWN OF DEATH Baltimore (12)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Armaccost Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Homemaker			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland		13b. COUNTY —		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIM. TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1310 Lakeside Avenue			
14. FATHER'S NAME First Middle Last George Davis				15. MOTHER'S MAIDEN NAME First Middle Last Adeline Lilly							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 215-05-0792D		17. INFORMANT Daughter BE5-0951 Mrs. HELEN B. COALE				Address 1310 Lakeside Avenue Baltimore, Maryland 21218			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from June 1, 1961, to May 2, 1969, that (I) (we) last saw the deceased alive on May 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Franklin E. Leslie						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 2, 1969			
22d. PHYSICIAN'S NAME (Type) Franklin E. Leslie						22e. ADDRESS 3501 St Paul St. Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial		23b. DATE May 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Rock Spring Episcopal Church Cem.			23d. LOCATION (City or Town) (County) (State) Forest Hill, Hartf. Co., Md. 21050				
24. FUNERAL DIRECTOR Joseph William Foster						ADDRESS W. Broadway & Williams Sts Belt Air, Maryland 21014		25a. REC'D BY REGISTRAR DAMAY 5 1969		25b. REGISTRAR'S SIGNATURE	



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MAY 7a Film G-73											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06649 CERTIFICATE OF DEATH 06647											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Grace D. Sheldrake						May Month 30 Day 1969 Year			10:41 PM		
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		11-28-1896		72 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
New Jersey		United States				Baltimore Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph Hospital			Homemaker					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6603 Eastern Parkway	
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
John B. Hine				Mary Jane de Gruchy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT		Address				
No			216-16-1071		Hubert J. Sheldrake		6603 Eastern Pkwy.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Pulmonary embolism, massive											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Phlebothrombosis, congestive heart failure,											
DUE TO, OR AS A CONSEQUENCE OF Myocardial infarction.											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from May 5, 1969, to May 30, 1969, that (I) (we) lost the deceased alive on May 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death.											
22b. SIGNATURE Eugenio Antonio, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED May 30, 1969			
22d. PHYSICIAN'S NAME (Type) Eugenio Antonio, M.D.						22e. ADDRESS 7620 York Road Towson Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6-3-69		Parkwood		Balto., Md.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc., 5305 Harford Rd.						JUN 2 1969		J. Charles Jones			

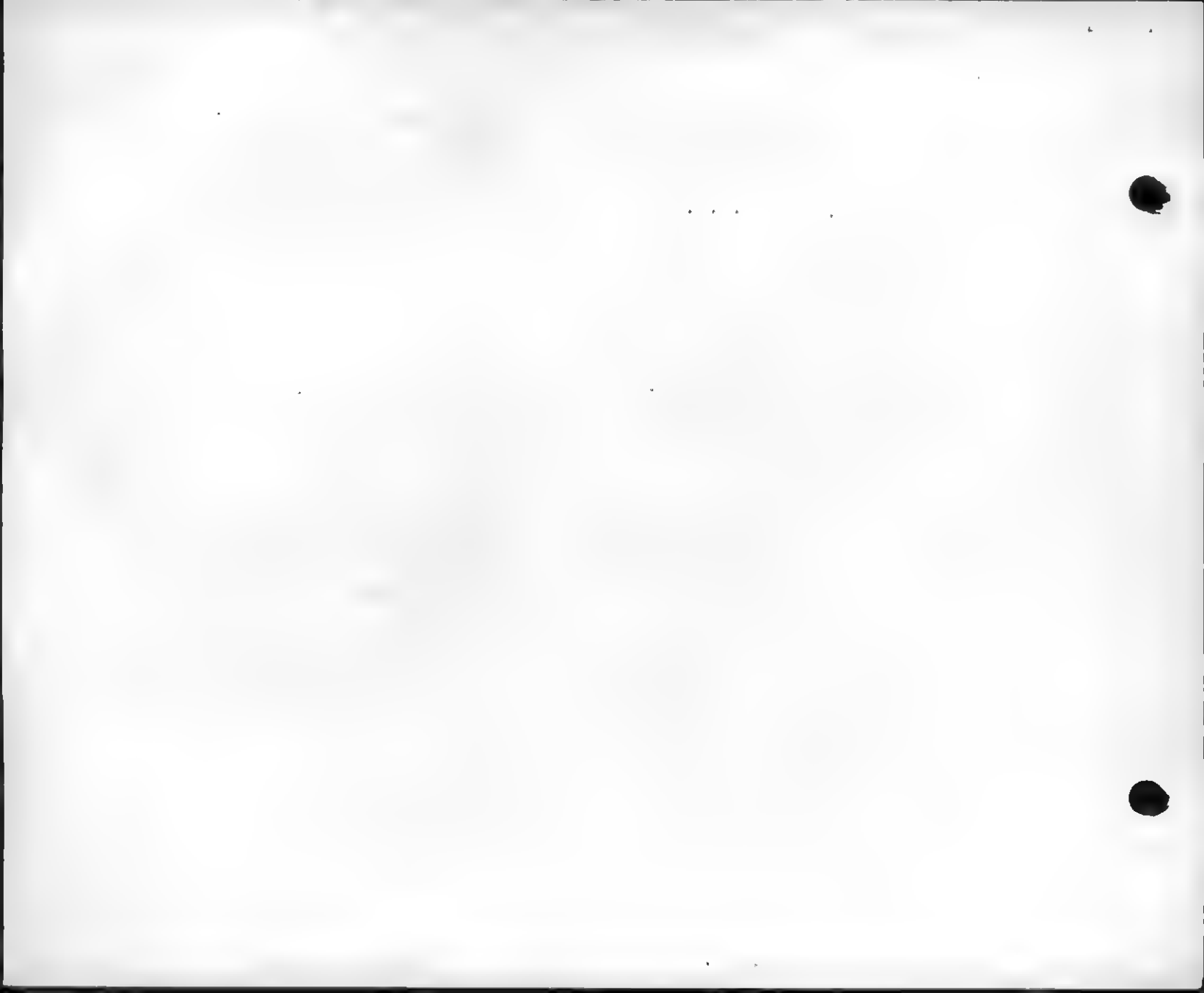


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VR 115
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First LESTER			Middle SHERMAN			Last SHIRLEY			2a. DATE OF DEATH Month 3, Day 1969 Year			2b. HOUR 2:54 AM		
3 SEX MALE			4 RACE WHITE			5 DATE OF BIRTH MARCH 17, 1909			6 AGE (In years last birthday) 60 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) BALTIMORE, MD.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md								
10 CITY OR TOWN OF DEATH BALTIMORE			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 23 RANDALL AVENUE			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FOODS			12b. KIND OF BUSINESS OR INDUSTRY RETAIL								
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 23 RANDALL AVENUE					
14 FATHER'S NAME DANIEL			First Middle Last SHERMAN			15. MOTHER'S MAIDEN NAME REBECCA			First Middle Last ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (or unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO 213-05-8580			17 INFORMANT MISS SHIRLEY SHERMAN, 23 TANDALL AVENUE			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>												minutes					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HASCH</u>												5 years					
DUE TO, OR AS A CONSEQUENCE OF																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At HOME FARM STREET FACTORY, OFFICE BUILDINGS, ETC.)			21f LOCATION Street or RFD No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>62</u> , to <u>5/3</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.																	
22b SIGNATURE <u>Joseph Shear</u>			22c PHYSICIAN'S NAME (Type) JOSEPH SHEAR			22d ADDRESS 6715 PARK HEIGHTS AVENUE			22e. DATE SIGNED 5/3/69								
23a BURIAL, CREMATION, REMOVAL, (Specify)			23b DATE 5-4-69			23c NAME OF CEMETERY OR CREMATORY BETH ISRAEL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND								
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6000 REISTERSTOWN ROAD			25a REC'D BY REGISTRAR MAY 6 1969			25b REGISTRAR'S SIGNATURE <u>Charles J. Gage</u>											



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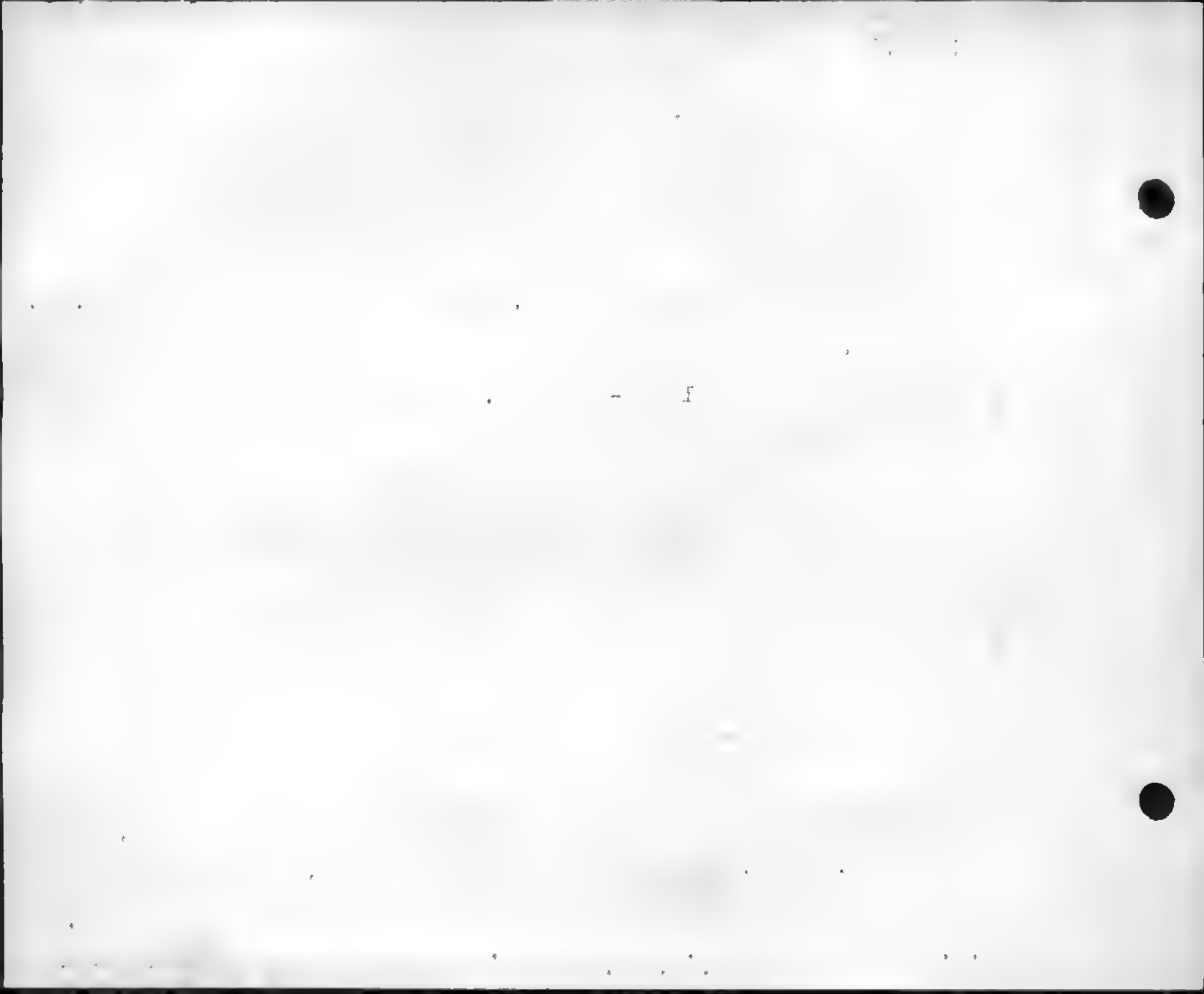
06651

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06649

1. DECEASED NAME (Type or print) Minnie L. Sherwood			2a. DATE OF DEATH Month 5 Day 27 Year 69			2b. HOUR 4:40 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-18-95		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? Maryland		8. MARRIED <input type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Baltimore 21204			11. NAME OF HOSPITAL OR INSTITUTION (If in hospital give street address) St. Joseph's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Balto., 21212		13d. INS. DE CITY, JM 15? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 5209 1/2 York Road, Balto., 12, Md		
14. FATHER'S NAME First John Middle Klein Last Unknown			15. MOTHER'S M A DEN NAME First Unknown Middle Unknown Last Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 216-16-2498		17. INFORMANT Address Mrs. Edith Johnson, 403 Woodford Rd.						
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Complete Heart Block DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Inferior Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arterotic Sclerotic Cardio Vascular Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 12, 1969 to May 27, 1969 , that (I) (we) last saw the deceased alive on May 27, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.											
22b. SIGNATURE Jami M. Punzalan DEGREE						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED May 27, 1969			
22d. PHYSICIAN'S NAME (Type) Dr. Jami M. Punzalan						22e. ADDRESS 7602 York Road, Baltimore, Maryland 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/31/69		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air			23d. LOCATION (City or Town) (County) (State) Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co., 4905 York Rd. Balto., 12, Md.						25a. REC'D BY REGISTRAR DATE MAY 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



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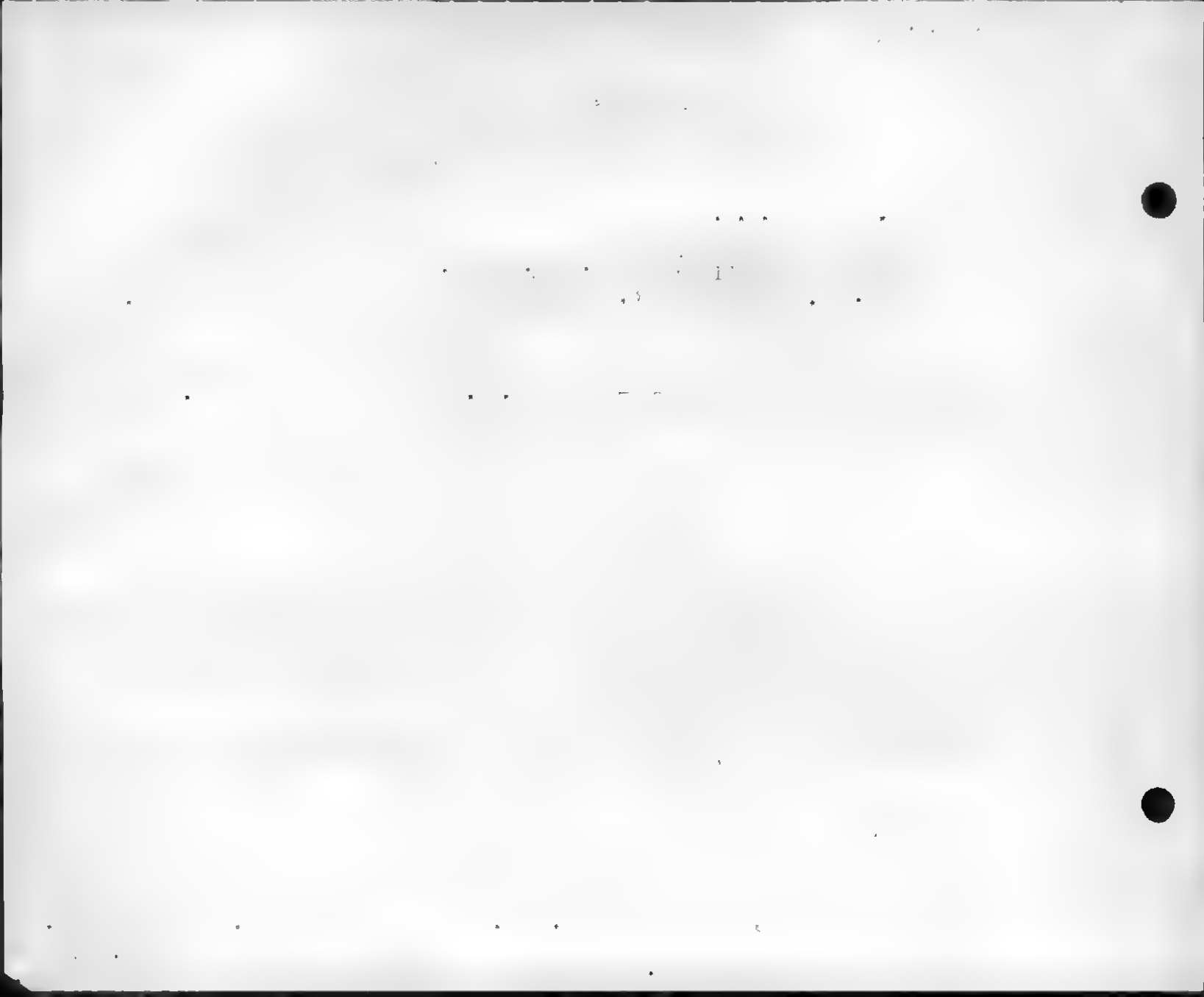
06652		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06650	
Item 10 Film 412 5/22/69 kk		CERTIFICATE OF DEATH			
1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year
Louis Paul Sieber		5	14	69	2b HOUR 1 52 A M
3 SEX M	4 RACE W	5 DATE OF BIRTH 7/14/03		6 AGE (In years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) Md	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County Md		
10 CITY OR TOWN OF DEATH Cwings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 222 Lyons Mill Rd		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Electrician	12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md	13b COUNTY Baltimore	13c CITY OR TOWN	13d INSIDE CITY & MTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER Box 222 Lyons Mill Rd	
4 FATHER'S NAME First Middle Last Frederick Louis Sieber		15 MOTHER'S MAIDEN NAME First Middle Last Jenny Cassidy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO. (If yes give war or dates of service) 215-01-3753 A		17. INFORMANT Address Daughter	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Undifferentiated pneumonia of lung</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic coronary artery disease & congestive heart failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/3</u> , 19 <u>69</u> , to <u>5/14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Arthur A. Serpick MD</u>		DEGREE MED		22c. DATE SIGNED 5/14/69	
22d. PHYSICIAN'S NAME (Type) Arthur A. Serpick MD		22e. ADDRESS 5601 Old Court Rd Baltimore, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 17, 1969	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Loring Byers Chapel 8728 Liberty Road 21133		25a. REC'D BY REGISTRAR DATE MAY 16 1969		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06653					06651				
1 DECEASED-NAME (Type or print) First Middle Last Roy SHIPLER Sisley					2a DATE OF DEATH May 25 1969			2b HOUR M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH May 22, 1884		6 AGE (In years last birthday) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Penna.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Randallstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Co. Gen. Hospt.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Grocer		12b KIND OF BUSINESS OR INDUSTRY Grocery			
13a USUAL RESIDENCE (Where deceased lived at time of admission) STATE Pa. Md.		13b USUAL RESIDENCE BEFORE ADMISSION Washington Co.		13c CITY OR TOWN Randallstown		13e STREET AND NUMBER 3715 Collier Rd.			
14. FATHER'S NAME First Middle Last Unknown Sisley					15. MOTHER'S MAIDEN NAME First Middle Last Unknown Shipler				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO 210-03-3843		17 INFORMANT Address Mr. Wm. Walsh 3715 Collier Rd. Randallstown					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>chronic</u> <u>10 yrs</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or RFD No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> , 19 <u>64</u> , to <u>5/25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b SIGNATURE <u>Ellin W. Ellis</u>		22c DEGREE M.D.		22d ATTENDING PHYS. <input checked="" type="checkbox"/>		22e MED. DIRECTOR <input type="checkbox"/>		22f STAFF PHYS. <input type="checkbox"/>	
22g PHYSICIAN'S NAME (Type) 8629 Liberty Rd		22h ADDRESS Randallstown Md.		22c. DATE SIGNED 5/26/69					
23a BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE May 25, 69		23c. NAME OF CEMETERY OR CREMATORY Donora Pa. Cem.		23d LOCATION (City or Town) (County) (State) Honora Pa. Washington Co.			
24. FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown				25a REC'D BY REGISTRAR MAY 28 1969		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06654					06652				
1 DECEASED-NAME (Type or print) First Middle Last Agnes Skwirut					2a. DATE OF DEATH Month Day Year May 5, 1969				
3 SEX female		4 RACE white		5 DATE OF BIRTH Feb. 2, 1902		6 AGE (In years last birthday) 67 YRS.		7b. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done at of working life, even if retired) CRANE CORP. SEAL			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7340 Manchester Rd.	
14. FATHER'S NAME First Middle Last Frank Skwirut					15. MOTHER'S MAIDEN NAME First Middle Last Anna Ochab				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO NO RE		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. 1579 IMMEDIATE CAUSE (a) Carcinoma of pancreas with metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home farm street factory) OFFICE BUILDING ETC.			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (he) (this hospital) attended the deceased from May 4 , 19 50 , to May 5 , 19 69 , that (I) (we) last saw the deceased alive on May 5 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Diomidis Pirovolidis					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5-5-69		
22d. PHYSICIAN'S NAME (Type) Diomidis Pirovolidis, M.D.					22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-8-69		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM.			23d. LOCATION (City or Town) (County) (State) DUNDALK MD.		
24. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC.		ADDRESS 501 S. CHESTER			25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

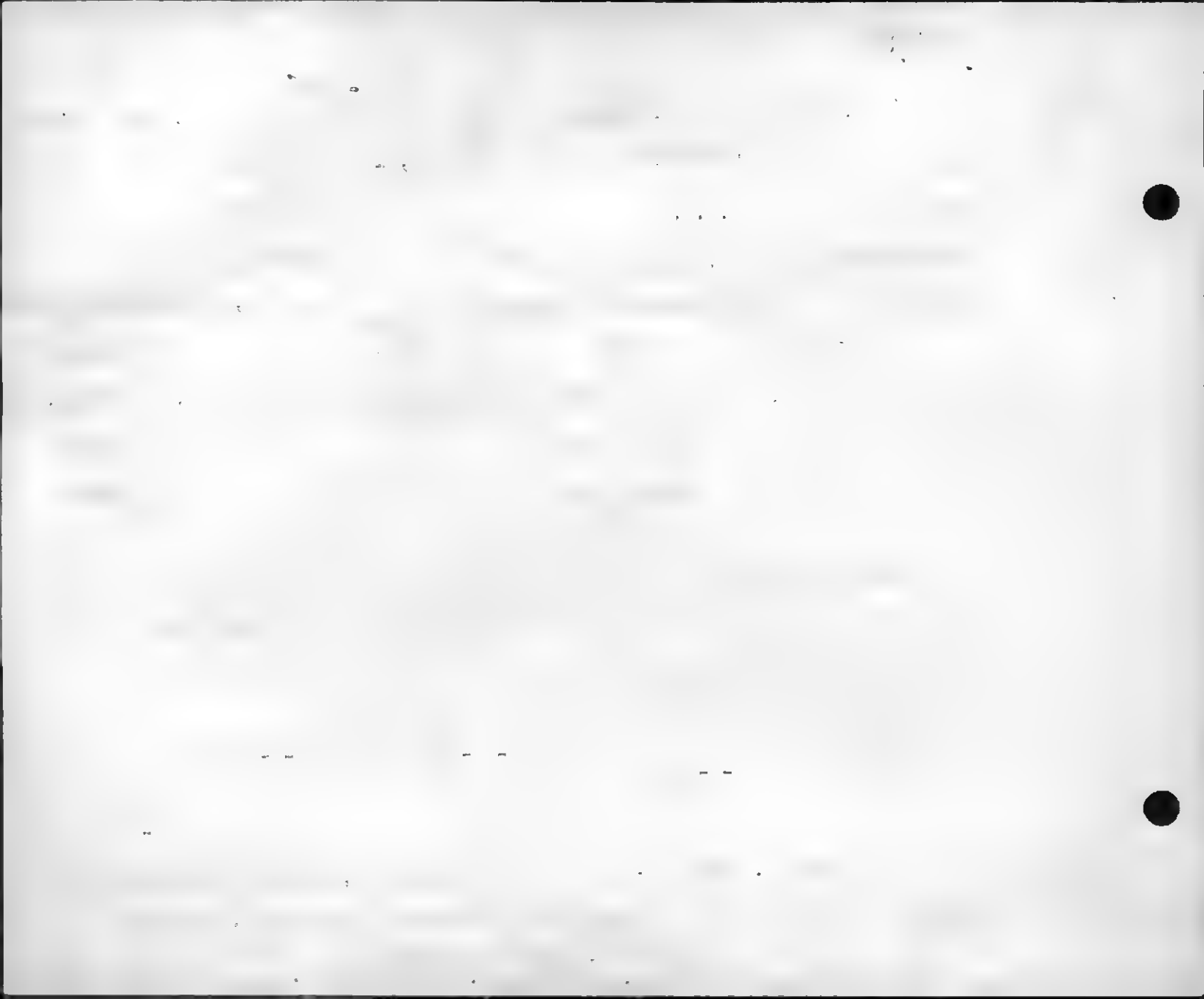


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-1-69

<div>06655</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06653</div>																
1 DECEASED NAME (Type or print)			First ARTHUR			Middle MERIDITH			Last SMITH			2a DATE OF DEATH Month MAY Day 7 , Year 1969			2b HOUR 12:45 ^A M	
3 SEX MALE			4 RACE CAUCASIAN			5 DATE OF BIRTH APRIL 29, 1925			6 AGE (In years last birthday) 44 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) VIRGINIA			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE			Md.				
10 CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) HOSPITAL VETERANS ADMINISTRATION			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BARTENDER			12b KIND OF BUSINESS OR INDUSTRY							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b COUNTY ANNE ARUNDEL			13c CITY OR TOWN JESSUP			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER BOX C55, HOLIDAY MOBIL ESTATE				
14 FATHER'S NAME First ARTHUR Middle SMITH Last SMITH			15 MOTHER'S MAIDEN NAME First EMMA Middle SOULS Last SOULS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give year or dates of service) WW II			16b. SOCIAL SECURITY NO. 231 18 9972			17 INFORMANT CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD				
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) HEPATIC COMA 719 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LIVER CIRRHOSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS YEARS																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c) DIABETES MELLITUS																
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3-28-69 , 19__, to 5-7-69 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5-7-69 , 19__, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (d.d.) (d.d.d.) view the body after death.																
22b SIGNATURE <i>Peter V. Juvan</i>			DEGREE PETER V. JUVAN, M. D.			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c DATE SIGNED 5-7-69							
22d. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.			22e ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND													
23a BURIAL CREMATION, REMOVAL (Specify) REMOVAL			23b DATE 5/10/69			23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY, FRONT ROYAL, VIRGINIA			23d. LOCATION (City or Town) (County) (State) FRONT ROYAL, VIRGINIA							
24 FUNERAL DIRECTOR JOSEPH N. ZANNINO FUNERAL HOME			ADDRESS 257 S. CONKLING ST. BALTIMORE, MD.			DATE MAY 10 1969			REGISTERED SIGNATURE <i>Charles Judge</i>							



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

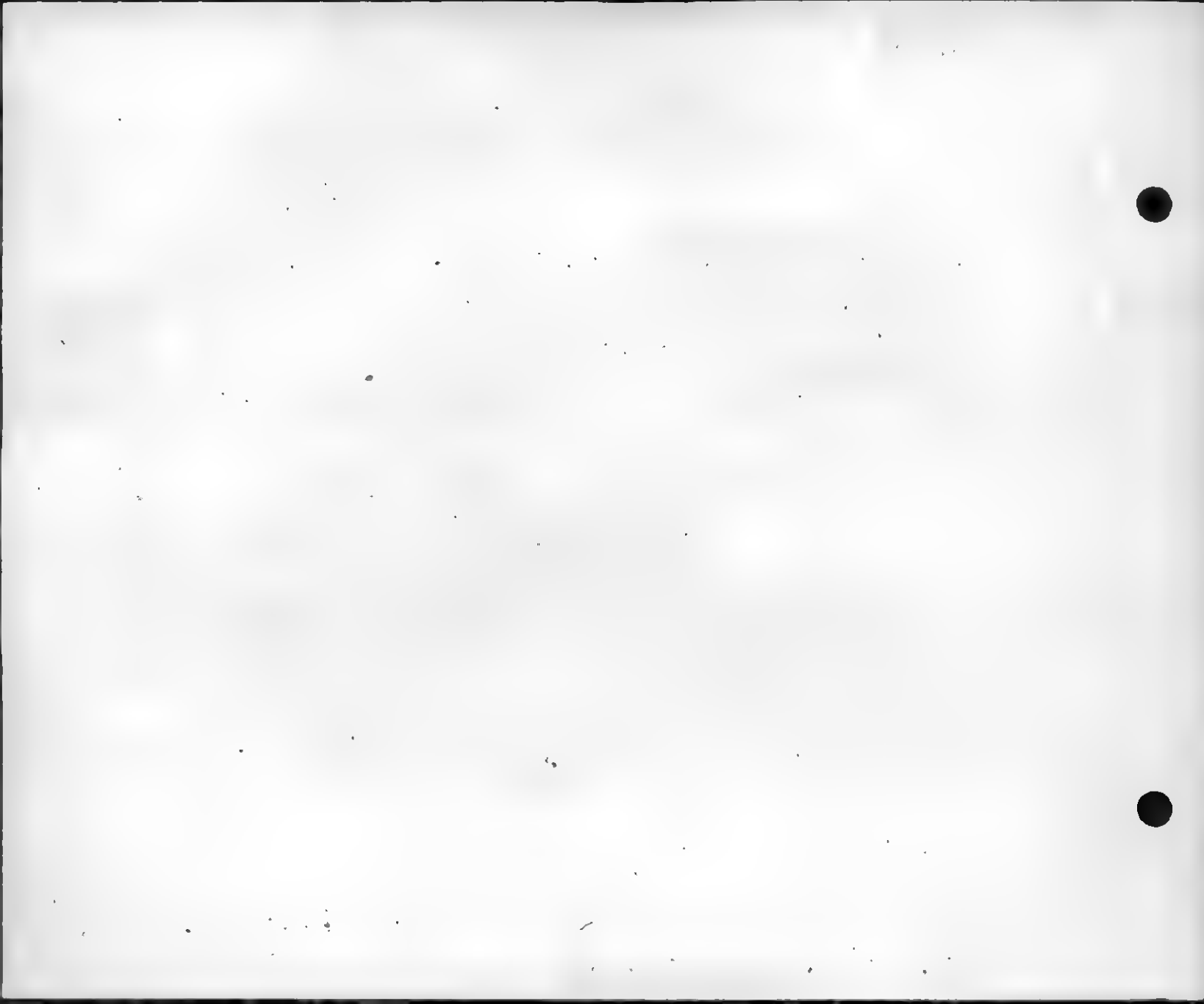
06656

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06654

1. DECEASED-NAME (Type or print) Edna May Smith			2a. DATE OF DEATH Month May Day 15 Year 1969			2b. HOUR M			
3 SEX Female		4. RACE White		5. DATE OF BIRTH July 22, 1899		6 AGE (In years last birthday) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Nursing Home		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Obrecht Road	
14. FATHER'S NAME First George Middle Brown Last Allen			15. MOTHER'S MAIDEN NAME First Ella Middle May Last Allen						
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. ?		17 INFORMANT Mrs Betty MAUS		Address Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT VENT. FAILURE 4109 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 60 days. 10 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) MULTIPLE CVA.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from SEPT 5-15 , 19 69 , to 5-15 , 19 69 , that (I) (we) last saw the deceased alive on 5-15 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE R. V. Houck, Jr.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-15-69	
22d. PHYSICIAN'S NAME (Type) R. V. Houck, Jr.		22e. ADDRESS Sykesville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-18-69		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or Town) (County) (State) Howard Co. Md.			
24. FUNERAL DIRECTOR Harry W. Haight				ADDRESS Sykesville, Md.		25a. RECD BY REGISTRAR MAY 20 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



TO HOSPITAL ■ ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06657
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 8 Film G412 5/19/69 kk
CERTIFICATE OF DEATH

06655

1. DECEASED-NAME (Type or print) MARY B. SMITH			2a. DATE OF DEATH Month 5 Day 9 Year 1969			2b. HOUR 6:45 P.	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 4-1-1895		6 AGE (In years lost birthday) 74 YRS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE	
10 CITY OR TOWN OF DEATH CATONSVILLE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3412 DAYTON DR.							
14 FATHER'S NAME First Middle Last OR AARON MICHAELSON			15 MOTHER'S MAIDEN NAME First Middle Last FANNIE ? SIEGEL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown		16b. SOCIAL SECURITY NO 216-56-3420		17 INFORMANT Chart of patient		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary insufficiency							years
DUE TO, OR AS A CONSEQUENCE OF (b) Intermittent cardiovascular disease							years
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis							years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (this hospital) attended the deceased from 10-28, 1932 to 5-9, 1969 , that (I) (we) lost saw the deceased alive on 5-9, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Juan A. Perez-Balboa				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-9-69	
22d. PHYSICIAN'S NAME (Type) JUAN A. PEREZ-BALBOA				22e. ADDRESS Spring Grove State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/11/69		23c. NAME OF CEMETERY OR CREMATORY MOSES MONTFIORE		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR DOL LEVINSON & BRAS INC. 6010 KESTERDAWN ROAD				25a. REC'D BY REGISTRAR MAY 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

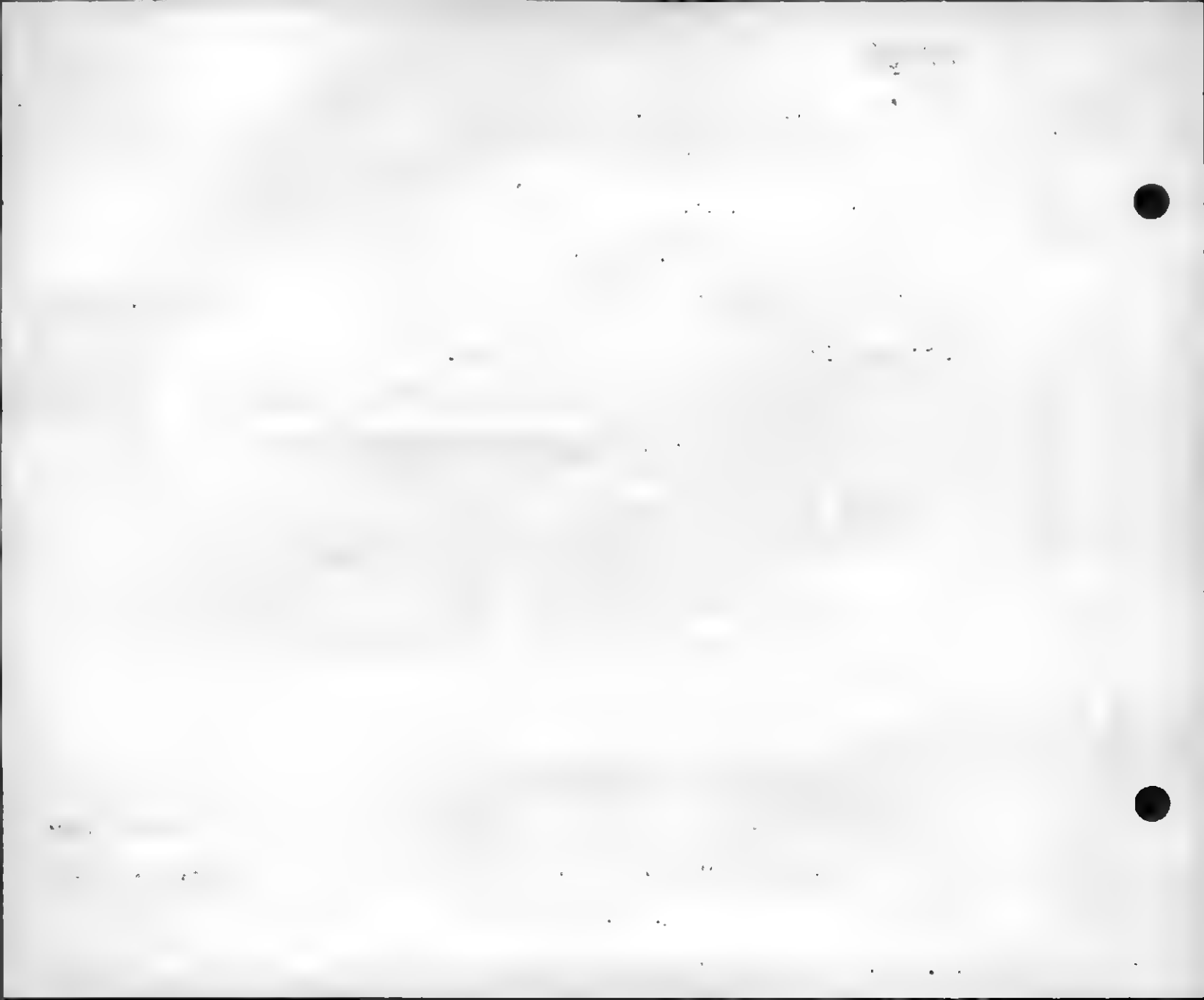


TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-78

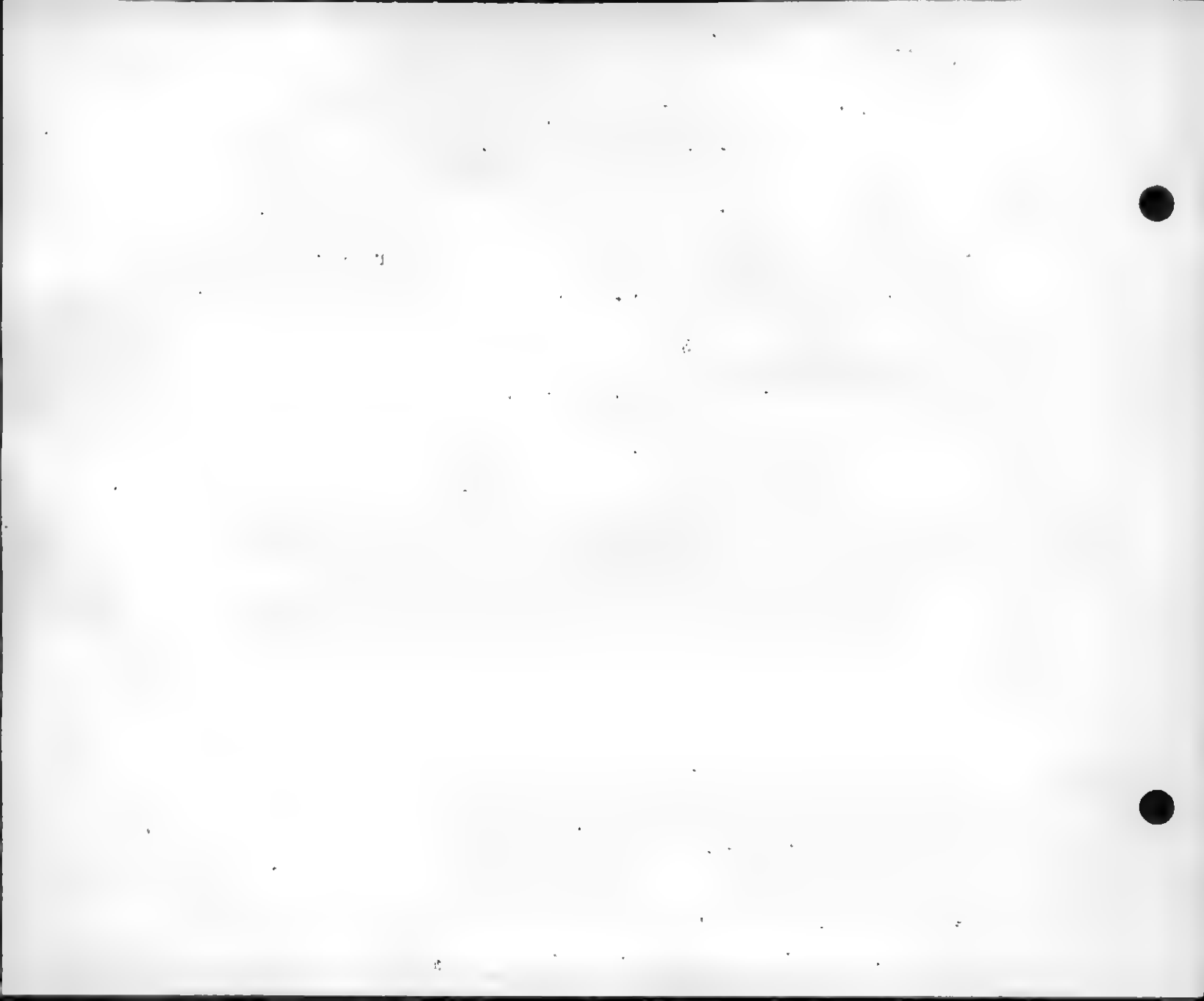
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
JEAN		E.		SOMERS		MAY		Month 14, Day 1969		4:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (n years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		OCTOBER 25, 1920		48 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				BALTIMORE, Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
TOWSON		ST. JOSEPH HOSPITAL		HOMELANDER							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		BALTIMORE						9520 RIDGELY AVE. #21234			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Struven Evans				Dora Taylor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
No		218-16-8587		Hospital records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Intracerebral Hemorrhage, right</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from May 13, 1969, to May 14, 1969, that (I) (we) lost the deceased on May 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Christiana Feliciano, M.D.</u> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED May 14, 1969			
22d. PHYSICIAN'S NAME (Type) Christiana Feliciano, M.D.						22e. ADDRESS 7620 York Road Baltimore, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		5/17/69		Gardens of Faith		Balto Co. Md.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
C.F. EVANS & SON 8802 Harford road						MAY 19 1969					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 06659 MARYLAND STATE DEPARTMENT OF HEALTH 06657 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. DECEASED-NAME (Type or print) CLIFTON BEALL STALEY						2a. DATE OF DEATH May 1 Day 1969			2b. HOUR 2:30 P.M.		
3 SEX male		4 RACE caucasian		5. DATE OF BIRTH August 19, 1903			6. AGE (In years last birthday) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 2 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 603 Stone Barn Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PHARMACIST			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. HOUSE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 603 Stone Barn Road		
14. FATHER'S NAME First Middle Last Leonard C. Staley				15. MOTHER'S MAIDEN NAME First Middle Last Hattie Beall							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO 212-30-2695		17. INFORMANT Address Mrs. Mary Gwendolyn Staley, Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic CA to brain</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lung.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 months. 6 months.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Phrenosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>February</u> , 19 <u>67</u> , to <u>May</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>(did not)</u> view the body after death.											
22b. SIGNATURE <u>E. P. Coffey Jr.</u>						22c. DATE SIGNED 5/2/69		22d. PHYSICIAN'S NAME (Type) F. P. Coffey Jr.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE May 5, 1969		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gards			23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland				
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Road, 21204						25a. REC'D BY REGISTRAR MAY 6 1969		25b. REGISTRAR'S SIGNATURE <u>G. L. ...</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06660

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06658

1. DECEASED NAME (Type or Print) Donna Lynn STAUFFER		First Middle Last		2a. DATE KNOWN OF DEATH Month 5 Day 8 Year 1969		2b. HOUR 5:30 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH Feb. 9, 1957	6. AGE (In years and birthday) 12 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD Month 5 Day 8 Year 1969	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland COUNTY ---		13c. CITY OR TOWN Baltimore		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4108 Newton Avenue	
14. FATHER'S NAME Donald Elwood STAUFFER		First Middle Last		15. MOTHER'S MAIDEN NAME Norma Elaine JONES		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---		16b. SOCIAL SECURITY NO. ---		17. INFORMANT ADDRESS Informant: Rosewood Records, Owings Mills, Md.			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Orthostatic Pneumonia due to Aspiration</i> DUE TO, OR AS A CONSEQUENCE OF <i>Injuries Sustained in Auto</i> (b) <i>Accident - Fractured Skull - brain damage, pneumothorax.</i> DUE TO, OR AS A CONSEQUENCE OF <i>fractured femur.</i> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>terminal</i> <i>8 mo.</i> <i>8 mo.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <i>Aug 22 '68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fractured Skull Pneumothorax</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>12:45 P.M. Aug 22 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Struck by a tractor</i>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>street</i>		21f. LOCATION Street or R.F.D. No. <i>Rio, Rd 4 Rogers Balto.</i>		City or Town County State <i>Md.</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>D. D. Caples</i>		EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED <i>5/8/69</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-12-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Mem. Gardens</i>		23d. LOCATION (City or Town) (County) (State) <i>Finksburg, Md.</i>	
24. FUNERAL DIRECTOR <i>G. Howard Strong 3207 W. North Ave.,</i>				25a. REC'D BY REGISTRAR DATE <i>MAY 12 1969</i>		25b. REGISTRAR'S SIGNATURE <i>"</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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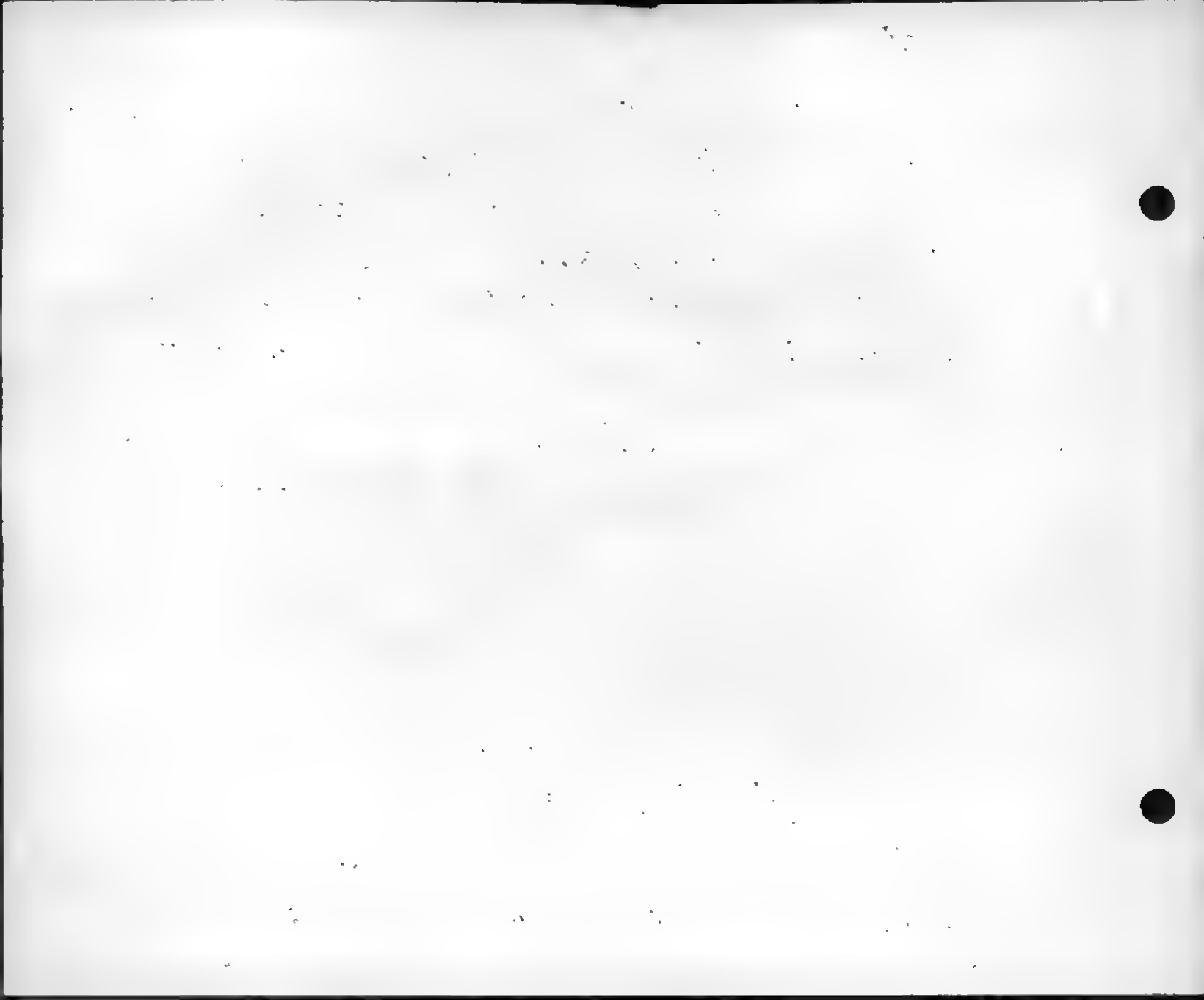
06661

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06659

1. DECEASED-NAME (Type or print) WILLIAM W. STEELE			2a. DATE OF DEATH Month MAY Day 14 Year 1969			2b. HOUR 3:2 AM		
3. SEX M		4. RACE W		5. DATE OF BIRTH 8/3/82		6. AGE (n years lost birthday) 86 YRS		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.		
10. CITY OR TOWN OF DEATH ESSEX			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 520 VIRGINIA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD			13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last JAMES A. STEELE			15. MOTHER'S MAIDEN NAME First Middle Last MADDOCKS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNK (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 217-18-073		17. INFORMANT J.W. STEELE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HOURS 5 YRS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from APRIL 8, 1958 , to MAY 14, 1969 , that (I) (we) last saw the deceased alive on MAY 14, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Joseph Miceli MD		DEGREE		ATTENDING PHYS.		MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type)		JOSEPH MICELI, M.D.		22e. ADDRESS 108 STAYLOR AVE.		22c. DATE SIGNED 5/16/69		
23a. BURIAL, CREMATON, REMOVAL (Specify)		23b. DATE 5/17/69		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION (City or Town) (County) (State) BALTO. MD.		
24. FUNERAL DIRECTOR J.G. CONNELLY SONS				ADDRESS 300 MACE		25a. REC'D BY REGISTRAR MAY 19 1969		
25b. REGISTRAR'S SIGNATURE Charles Judge								



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06662

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06660

1 DECEASED NAME (Type or Print) <i>CORA Elizabeth Stiffler</i>			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <i>MAY</i> Day <i>14</i> Year <i>1969</i>			2b HOUR <i>6A</i> M		
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>8 Aug 83</i>	6 AGE (in years last birthday) <i>85</i> YRS	7 UNDER 1 YEAR MONTHS _____ DAYS _____	7 UNDER 24 HRS HOURS _____ MIN _____	2c DATE PRONOUNCED DEAD Month <i>MAY</i> Day <i>14</i> Year <i>1969</i>		
7a BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>BALTIMORE</i> Md.		
10 CITY OR TOWN OF DEATH <i>BALTO-BAINESVILLE</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1909 East Joppa Rd</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a US. RESIDENCE (Where deceased lived, if institution admission) STATE <i>Maryland</i>		13b COUNTY <i>BALTIMORE</i>		13c CITY OR TOWN <i>BAINESVILLE</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>1909 East Joppa Rd</i>
14. FATHER'S NAME First <i>JOSEPH</i> Middle _____ Last <i>BOSLEY</i>			15 MOTHER'S M. NAME First <i>KATE</i> Middle <i>CARMAN</i> Last _____					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b SOCIAL SECURITY NO <i>none</i>		17. INFORMANT <i>FAMILY RECORDS</i>			ADDRESS
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Gastrointestinal hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immed.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerosis Cordis; vascular disease</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John C. Hyle</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>5-14-69</i>		
EXAMINER'S NAME (Type) <i>JOHN C. Hyle</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <i>7527 Belvidere Rd</i>		
23a BURIAL CREMATION BURIAL		23b. DATE <i>MAY 17, 1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>PARKWOOD CEMET.</i>		23d LOCATION (City or Town) <i>Parkville, Md.</i>		(County) _____ (State) _____
24 FUNERAL DIRECTOR <i>John Burns, Sr., Towson, Md.</i>			ADDRESS			25a REC'D BY REG. STR. <i>MAY 15 1969</i>		25b. REG. STR.'S SIGNATURE

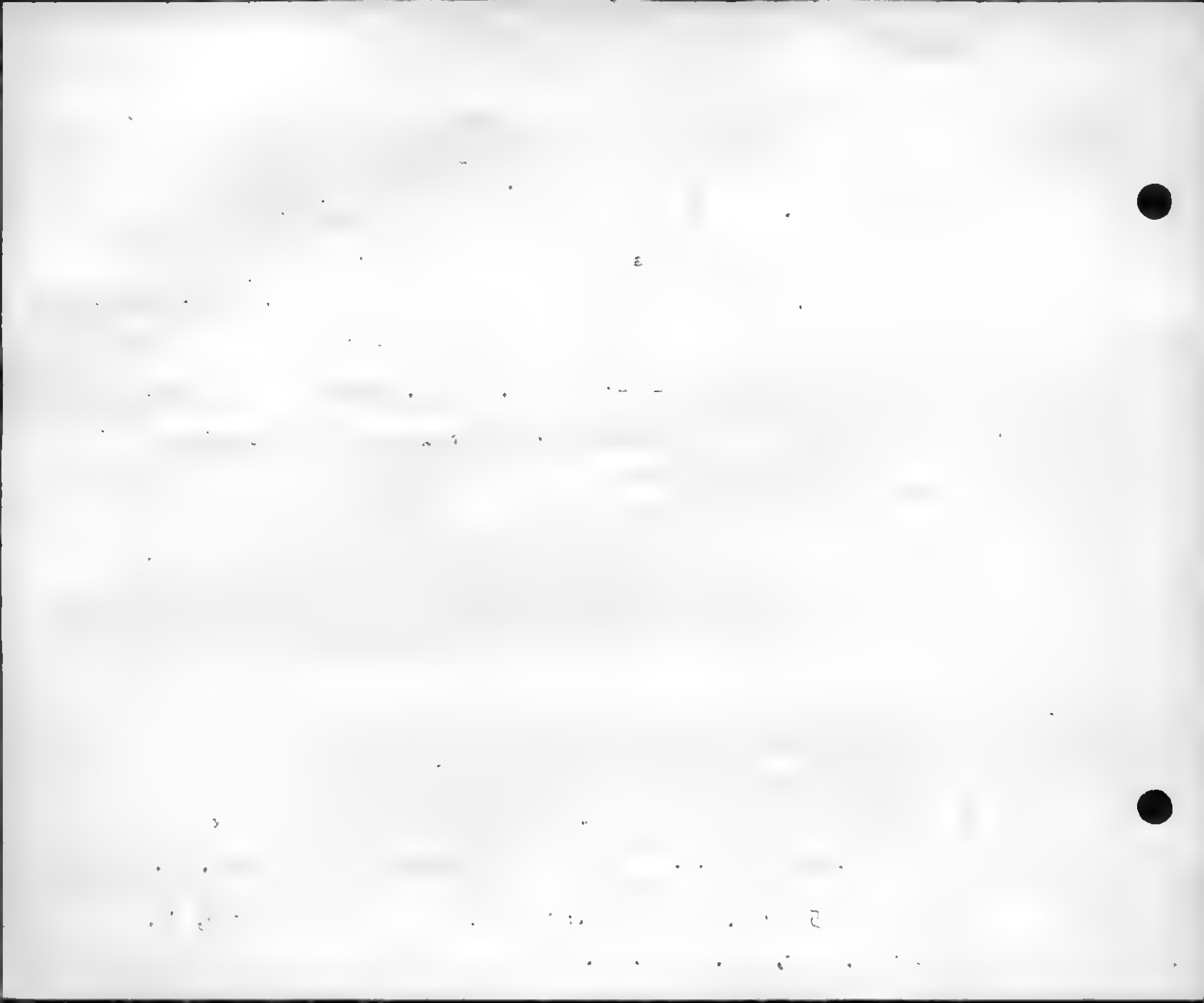


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-14
304 REV. 1/68

<div>06663</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06661</div>										
1. DECEASED NAME (Type or print)			First Middle Last			20. DATE OF DEATH				
Marie Stella Stoker						Month 5 Day 7 Year 69				
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female	White		9-12-25-24			44 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Baltimore Md.		USA				Baltimore Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			St. Joseph's Hospital			housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Baltimore		YES		1408 Herd Lane Drive, 21212	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last Emory Parson			First Middle Last Catherine Koenig							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address				
No			217-12-9823			Mr. Clay G. Stoker (Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent and metastatic renal cell carcinoma										
1870 DUE TO, OR AS A CONSEQUENCE OF (b) _____										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from May 5, 1969, to May 7, 1969, that (X) (we) lost the deceased alive on May 7, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Samuel Lee</i>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-8-69		
22d. PHYSICIAN'S NAME (Type) Samuel Lee, M.D.						22e. ADDRESS 7620 York Road, Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/12/69.		Parkwood Cemetery		Baltimore, Md.				
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR DATE MAY 8 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06664

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06662

1 DECEASED-NAME (Type or print) First Middle Last Arthur W. Stelworthy			2a DATE OF DEATH Month Day Year 5 16 69			2b. HOUR 4:23 PM			
3. SEX Male		4 RACE Caucasian		5. DATE OF BIRTH 6/27/93		6 AGE (n years last birthday) 76 YRS		7. UNDER 24 HRS MONTHS DAYS HOURS M N	
7a BIRTHPLACE (State or foreign country) Louisiana, N.H.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md			
1d CITY OR TOWN OF DEATH WINDY LAWN		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Baltimore Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Lithographer		12b. KIND OF BUSINESS OR INDUSTRY Lithography			
13a. USUA. RES DENCE (Where deceased lived, if institution Res dence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN WINDY LAWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6603 Knolls Ave.	
14 FATHER'S NAME First Middle Last Charles - Stelworthy			15. MOTHER'S MA DEN NAME First Middle Last Celia Reiser						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO. 037-01-9402		17 INFORMANT Wife - Mrs. C. V. Stelworthy		Address			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coccy Thrombosis 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis that disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1911 1912									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/31, 1966, to 6/16, 1967, that (I) (we) last saw the deceased alive on 12/18, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Edwin J. Pierpont, M.D.				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 6/16/69	
22d. PHYSICIAN'S NAME (Type) EDWIN J. PIERPONT, M.D.				22e. ADDRESS 8224 WILKESVILLE RD - BALTIMORE, MD					
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b DATE May 19, 1969		23c NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24 FUNERAL DIRECTOR Loring Byers Chapel 8728 Liberty Road 21133				25a REC'D BY REGISTRAR MAY 21 1969		25b REGISTRAR'S SIGNATURE Charles J. J. J.			

VA 45M



w/r.H. 6/12/69jp

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06665

CERTIFICATE OF DEATH

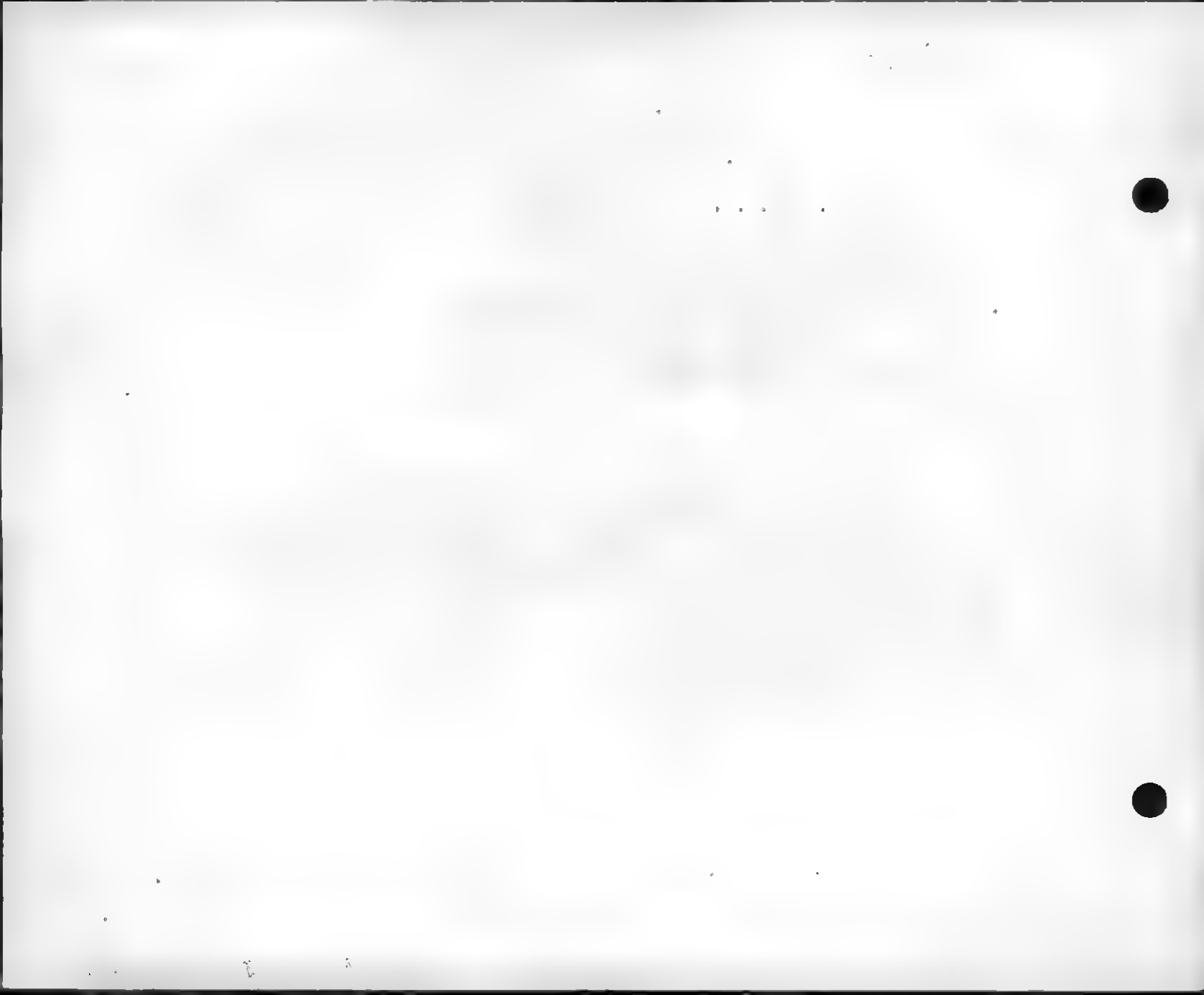
06663

1. DECEASED NAME (Type or print) First Middle Last Joseph I. Streett			2a. DATE OF DEATH Month Day Year 5 31 1969			2b. HOUR 11:32 AM	
3 SEX Male		4 RACE Cau.		5 DATE OF BIRTH 4-23-1907		6 AGE (In years last birthday) 62 YRS	
7a BIRTHPLACE (State or foreign country) Harford Co.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Bradshaw		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bradshaw Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Edgewood Arsenal		12b. KIND OF BUSINESS OR IND. STRY Electrician	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Balto.		13c. CITY OR TOWN Bradshaw		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Bradshaw Road 21o21		14 FATHER'S NAME First Middle Last Francis Streett		15. MOTHER'S MAIDEN NAME First Middle Last Mary Webster		Address 21221 Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. (If yes give year of date of service) WW II		17 INFORMANT Mrs Elizabeth Streett Bradshaw Rd. Bradshaw		Address 21221 Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Emory J. Linder</u>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>May 31, 1969</u>			
22d. PHYSICIAN'S NAME (Type) Dr. Emory J. Linder		22e. ADDRESS 902 Averill Road Joppa Md. 21085					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-2-1969		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Parkville Balto. Md	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236				25a. REC'D BY REGISTRAR JUN 4 1969		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

Released By Med Examiner M Hyle 7527 Belair Rd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M 1/69

06666

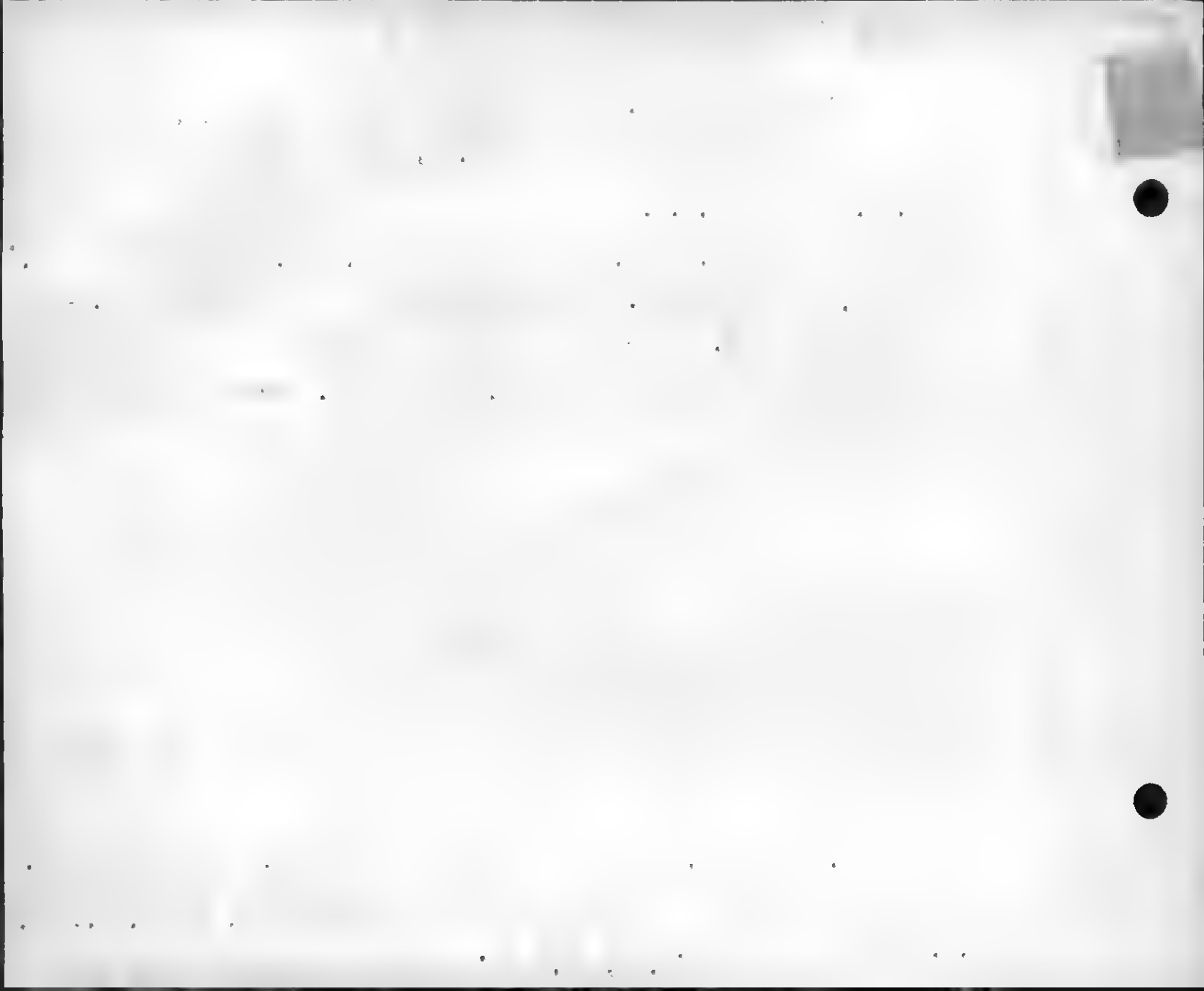
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06664

1. DECEASED NAME (Type or print) Wilbur A. Streett			2a. DATE OF DEATH Month May Day 19 Year 1969			2b. HOUR M				
3 SEX M		4. RACE W		5. DATE OF BIRTH Feb. 23, 1906		6. AGE (in years last birthday) 63 YRS.		7. UNDER YEAR MONTHS 63 DAYS 00 HOURS 00 MIN 00		
7a. BIRTHPLACE (State or foreign country) Balto., Md.		7b. CIT. ZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md				
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Gr. Balto. Medical Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Elec. Engineer			12b. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Cardiff Hall Apt. B-4	
14. FATHER'S NAME First William Middle G. Last Streett			15. MOTHER'S M.A.D.E.N NAME First Lollie Middle Jones Last Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes give war or dates of service) WWII			16b. SOCIAL SECURITY NO 212-05-6702		17. INFORMANT Address Mrs. Elizabeth D. Streett (Same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF coronary insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 12 yrs. (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4/13 , 19 67 , to 3/19 , 19 69 , that (I) (we) last saw the deceased alive on 3/16 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. George T. Gilmore						22c. DATE SIGNED 5/20/69				
22d. PHYSICIAN'S NAME (Type) Dr. George T. Gilmore						22e. ADDRESS 1717 York Road, Lutherville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/22/69		23c. NAME OF CEMETERY OR CREMATORY Parkwood			23d. LOCATION (City or Town) (County) (State) Parkville, Balto. Co., Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.						25a. REC'D BY REGISTRAR 4905 York Rd. Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1534
30M REV 11/68

06667

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06665

1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR						
John		Strumsky						Month 5 Day 7 Year 1969			1:15 PM						
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		6/17/85				83 YRS		10 MONTHS 21 DAYS		HOURS MIN					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH											
Baltimore		United States				Baltimore County Md.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY					
Towson				Stella Maris Hospice				Butcher									
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
Md.				Baltimore		Baltimore		YES		2900 Southern Ave.							
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME							
Frank				Strumsky						Annetta Cabella							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17. INFORMANT				Address							
u				219-32-0549-A		Stella Maris Hospice				Towson Md. 21204							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>																	
4109 DUE TO, OR AS A CONSEQUENCE OF																	
(b) <u>ASCD-</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No		City or Town		County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>68</u> , to <u>May</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>E. Lee Robbins</u>												DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5/7/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>E. Lee Robbins M.D.</u>												22e. ADDRESS <u>612 Mockingbird Lane</u>		21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				5-9-69		Parkwood Cemetery				Taylor Ave. Baltimore Md.							
24. FUNERAL DIRECTOR ADDRESS								25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE							
Howard H. Hubbard 4107 Wilkens Ave. 21229								MAY 12 1969		<u>[Signature]</u>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06663

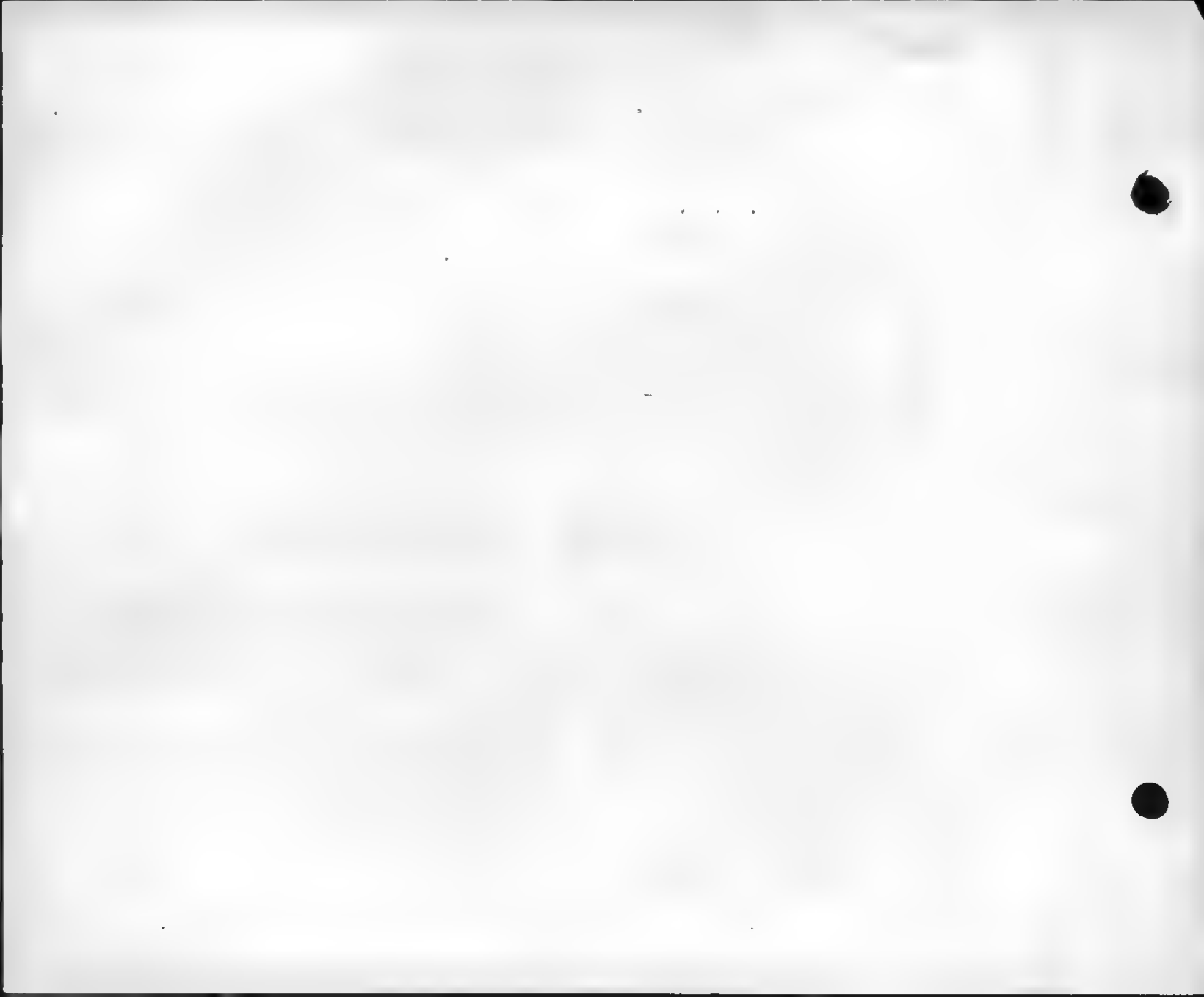
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06666

1 DECEASED-NAME (Type or print) Oris		First Oris	Middle O.	Last Stutler	2a DATE OF DEATH Month May Day 15 Year 1969		2b HOUR 8:30 AM
3 SEX Male		4 RACE White		5 DATE OF BIRTH 7/29/85		6 AGE (in years lost birthday) 83 YRS.	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) West Virginia		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md	
10 CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hosp.		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Engineer		12b KIND OF BUSINESS OR INDUSTRY Bendix	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Towson		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Louis		Middle Stutler		Last Stutler		15 MOTHER'S MAIDEN NAME First Abigail	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b SOCIAL SECURITY NO 1908		17 INFORMANT Records--Spring Grove State Hospital		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) worked Myocardium and uremia 41-4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) chronic brain syndrome DUE TO, OR AS A CONSEQUENCE OF (c) advanced atherosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (X) (this hospital) attended the deceased from 9/6/68 , 19__, to May 15 , 19 69 , that (X) (we) last saw the deceased alive on May 15 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death							
22b SIGNATURE Miguel A. Heredia, M.D.		DEGREE M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 5/15/69	
22d. PHYSICIAN'S NAME (Type) MIGUEL A. HEREDIA, M.D.		22e ADDRESS Spring Grove State Hospital					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE May 17, 69		23c NAME OF CEMETERY OR CREMATORY Sun Set Memorial		23d LOCATION (City or Town) (County) (State) Lost Creek West Va.	
24 FUNERAL DIRECTOR Loring Myers 8728 Liberty Rd. Randallstown		ADDRESS		25a REC'D BY REGISTRAR DATE MAY 19 1969		25b REGISTRAR'S SIGNATURE W. Thomas Jones	

MEDICAL CERTIFICATION

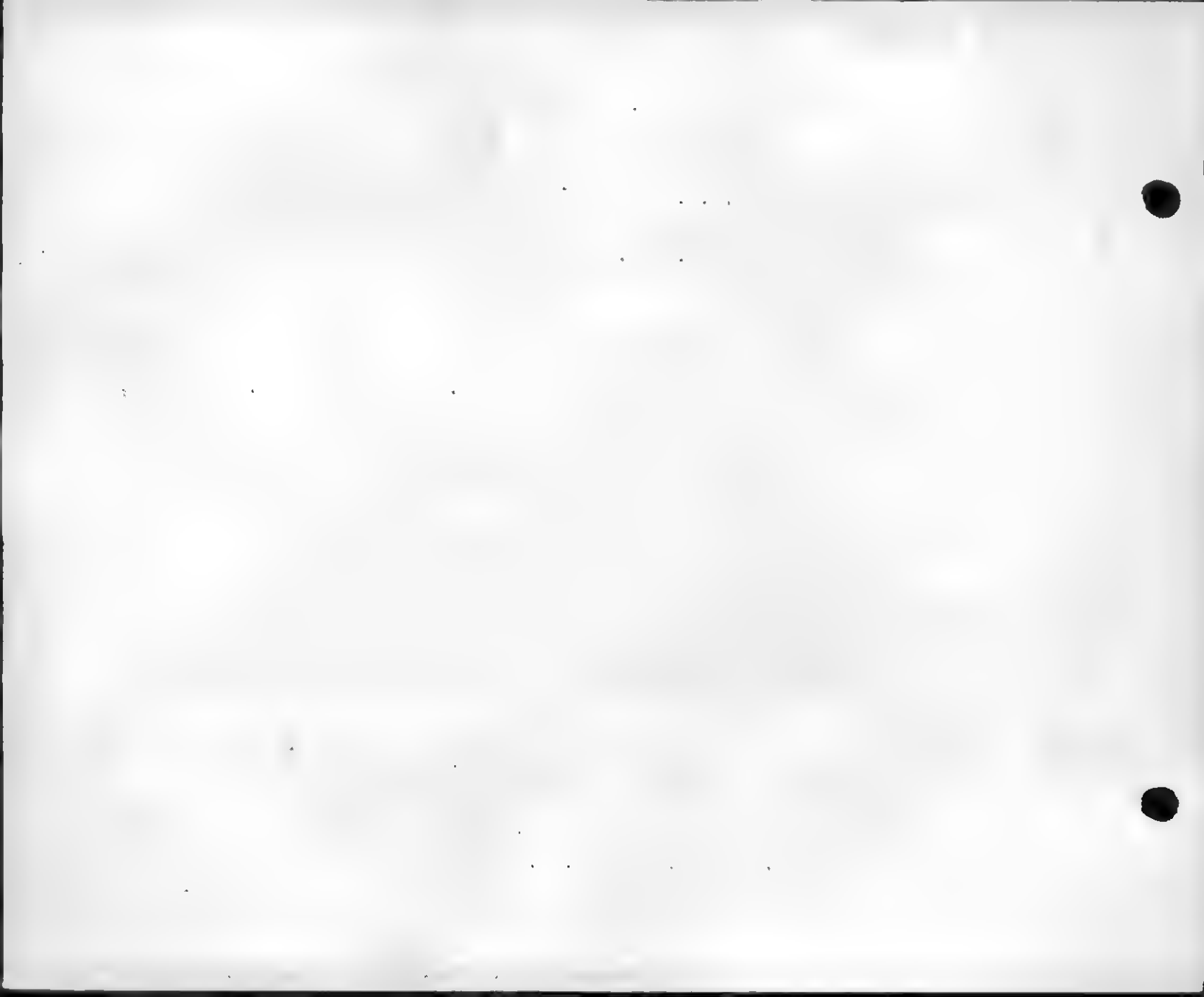


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VR A13
45M

06669										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06667																																							
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last WILLIAM A. SZCZESNIAK										Month Day Year 5 25/69										11:00PM																																							
3 SEX MALE										4 RACE WHITE										5 DATE OF BIRTH 1/26/08										6 AGE (n years last birthday) 61 YRS										7 UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CIT. ZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9 COUNTY OF DEATH BALTIMORE,										Md.																			
10 CITY OR TOWN OF DEATH FORT HOWARD										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER										12b. KIND OF BUSINESS OR INDUSTRY Construction																													
13a. USUAL RESIDENCE (Where deceased had adm. ssion) STATE Maryland										13b. CITY OR TOWN Baltimore										13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13d. STREET AND NUMBER 222 S. Broadway																													
14. FATHER'S NAME First Middle Last Anthony Szczesniak										15. MOTHER'S MAIDEN NAME First Middle Last Josephine Harra										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war and dates of service) Yes, none unknown) WW II										16b. SOCIAL SECURITY NO 217 05 19 94										17 INFORMANT CLIN. RECORDS, VA HOSP. FT HOWARD, MD.																			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) INATION 1460 DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF OROPHARYNX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (At home, farm, street, factory) (Office buildings, etc.)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (H) (this hospital) attended the deceased from 3/7/69, 19__, to 5/25/69, 19__, that (H) (we) last saw the deceased alive on 5/25/69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (do not) view the body after death.																																																											
22b. SIGNATURE George C. McElfatrick, M.D.										22c. DATE SIGNED 5/26/69										22d. ADDRESS VAH FORT HOWARD, MARYLAND																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 5-28-69										23c. NAME OF CEMETERY OR CREMATORY BALTIMORE, NATIONAL										23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.																													
24. FUNERAL DIRECTOR										25. REGD BY REGISTRAR WILLIAM FIALKOWSKI FUNERAL HOME 2007 Eastern Ave. Baltimore, MD DATE MAY 29 1969										25b. REGISTRAR'S SIGNATURE W. Fialkowski																																							



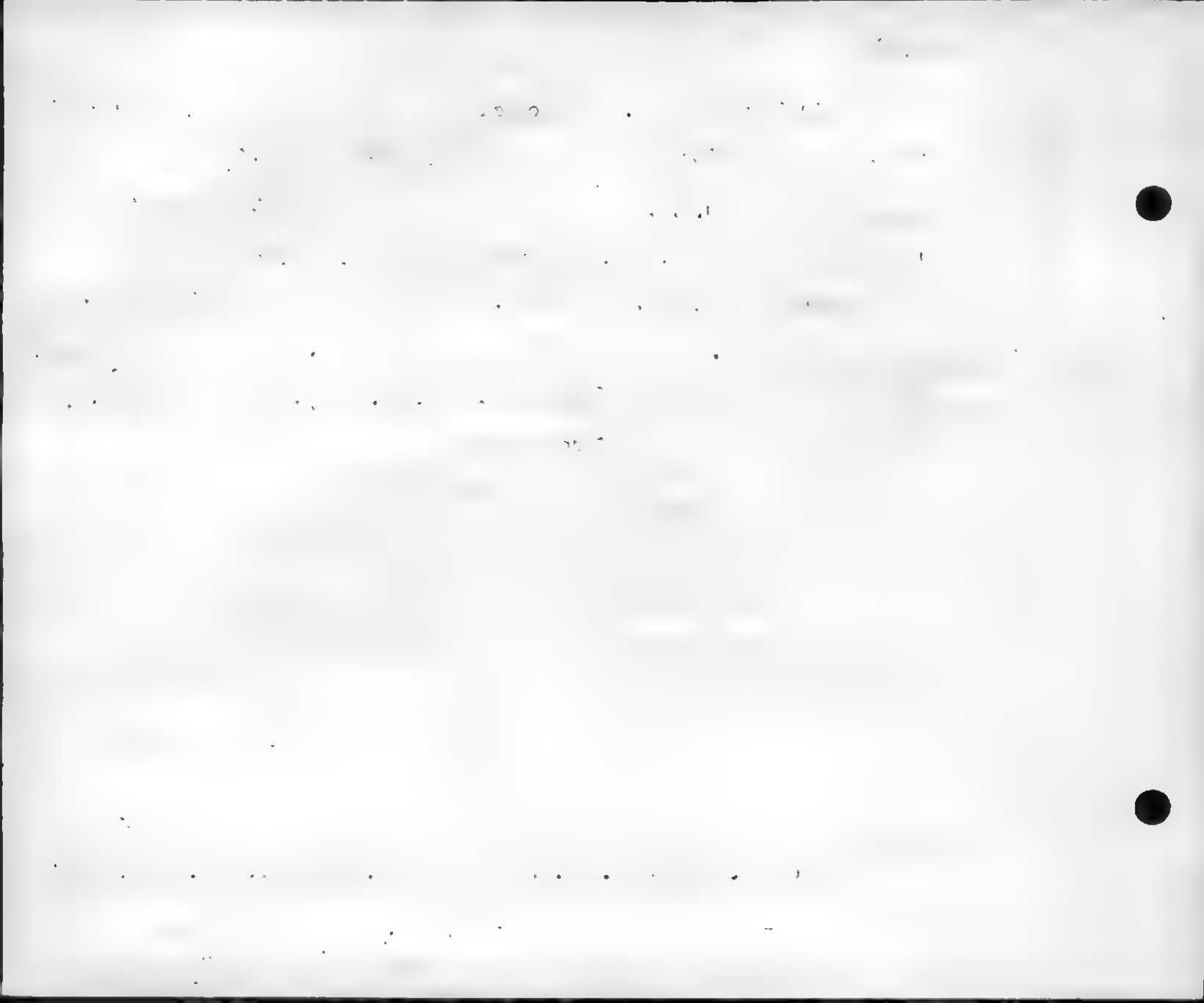
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VR A15 (4)
30M REV. 1/68

06670										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06668									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Virginia Middle M. Last Tennant										Month 5 Day 31 Year 1969										2:10 PM									
3 SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.														
female			white			3-23-1922			47 YRS.																				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Maryland			U.S.A.						Baltimore County						Md														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY																				
Towson			St. Joseph Hospital			homemaker																							
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER																	
Maryland			Balto.			Balto.						2211 Eastern Ave.																	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
Henry D. Volz					Helen Elding																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)					16b. SOCIAL SECURITY NO					17. INFORMANT					Address														
No					216-12-3748					Mr. Cecil C. Tennant					21220 2211 Eastern Ave.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinomatoses																													
DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Ovary																													
DUE TO, OR AS A CONSEQUENCE OF																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from 8-5-68, 19, to 5-31, 19 69, that (I) (we) last saw the deceased alive on 5-31-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
Joseph A. Knell, Jr. M.D.										5/31/69																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
Joseph A. Knell, Jr. M.D.										1001 St. Paul St., Balto Md. 21202																			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)																				
Burial			6-2-1969			Moreland Memorial			Baltimore.						Md.														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Lassahn Funeral Home 7401 Belair Road 21236										JUN 4 1969										Klemm Judge									

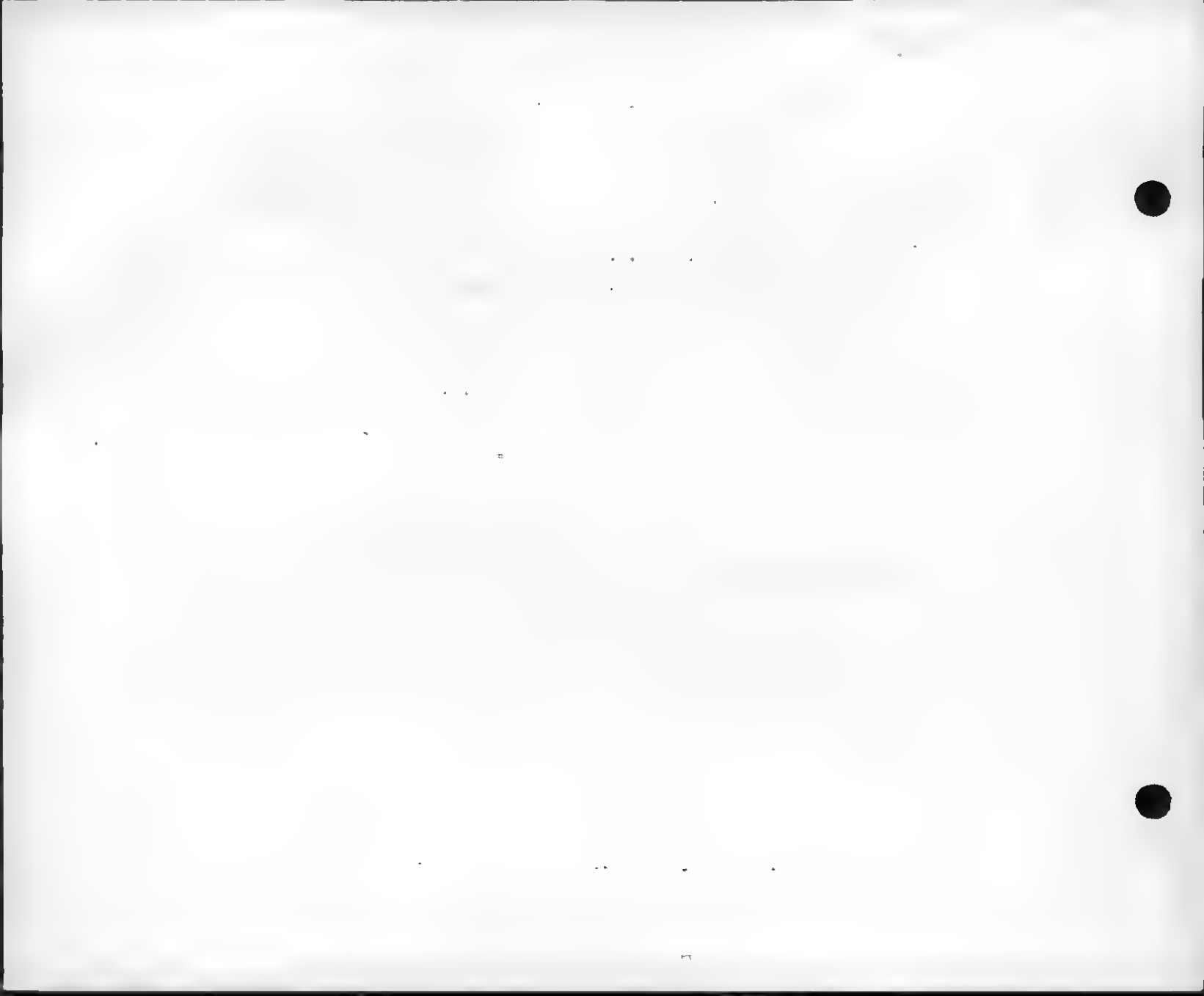
MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06671					06669				
1 DECEASED-NAME (Type or print)					First Middle Last		2a. DATE OF DEATH		2b. HOUR
STANLEY Dean THAWLEY							Month Day Year		9:45A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		2/20/94		75 YRS		MONTHS DAYS HOURS M N	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		U.S.A.				BALTIMORE			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of previous year, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
FORT HOWARD			VET. ADM. HOSPITAL			MACHINIST		Webb's Mfg	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS-DE CITY-LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
MARYLAND			ANNE ARUNDEL		GLEN BURNIE				BOX 165B Route 1
14 FATHER'S NAME			15. MOTHER'S M A D E N NAME						
First Middle Last			First Middle Last						
CHARLES THAWLEY			CARRIE E. SMITH						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOC AL SECURITY NO		17 INFORMANT Address				
YES			WW I		217 03 28 06 CLIN.RECORDS, VAH FT HOWARD, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RETROPERITONEAL HEMORRHAGE MASSIVE									RECENT
4411 DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURE ANEURYSM ABDOMINAL AORTA									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
ARTERIOSCLEROTIC HEART DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21a INJURY OCCURRED		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		Street or R.F.D. No.		City or Town	County State
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a I certify that (X) (this hospital) attended the deceased from 2/13/69, 19__, to 5/16/69, 19__, that (H) (we) last saw the deceased alive on 5/16/69, 19__, and that in (MY) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED
22d PHYSICIAN'S NAME (Type)					22e ADDRESS				
JOHN D. TALBERT, M. D.					VAH FORT HOWARD, MARYLAND				
23a BURIAL, CREMATION, or other disposal (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
BURIAL		5/20/69		BALTIMORE NATIONAL		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR		25b REC'D BY REGISTRAR		25c REGISTRAR'S SIGNATURE					
		237		PATAPSCO AVENUE, BALTIMORE, MD 21201		Charles Judge			



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VR 113 (4)
45M 5/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year	
Carrie				Thomas				May 12, 1969	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 FINDER - YEAR	
female		Negro		March 8, 1905		64 YRS		MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U. S.				Baltimore		Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonville		SPRING GROVE STATE HOSP.		housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY, LIMITY		13e. STREET AND NUMBER			
Md.		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1832 Eagle Street			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Nelson Henson		Bertha Underdow				214-20-4464		Records: SPRING GROVE STATE HOSPITAL	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from March 4, 1969, to May 12, 1969, that (X) (we) last saw the deceased alive on May 12, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
		5-12-69		Anthony J. Young, M.D.		SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21208			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/16/69		Baltimore National		Baltimore Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Earl Gilmore		MAY 14 1969		Charles Judge					



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VR A13 (4) 45M 1969

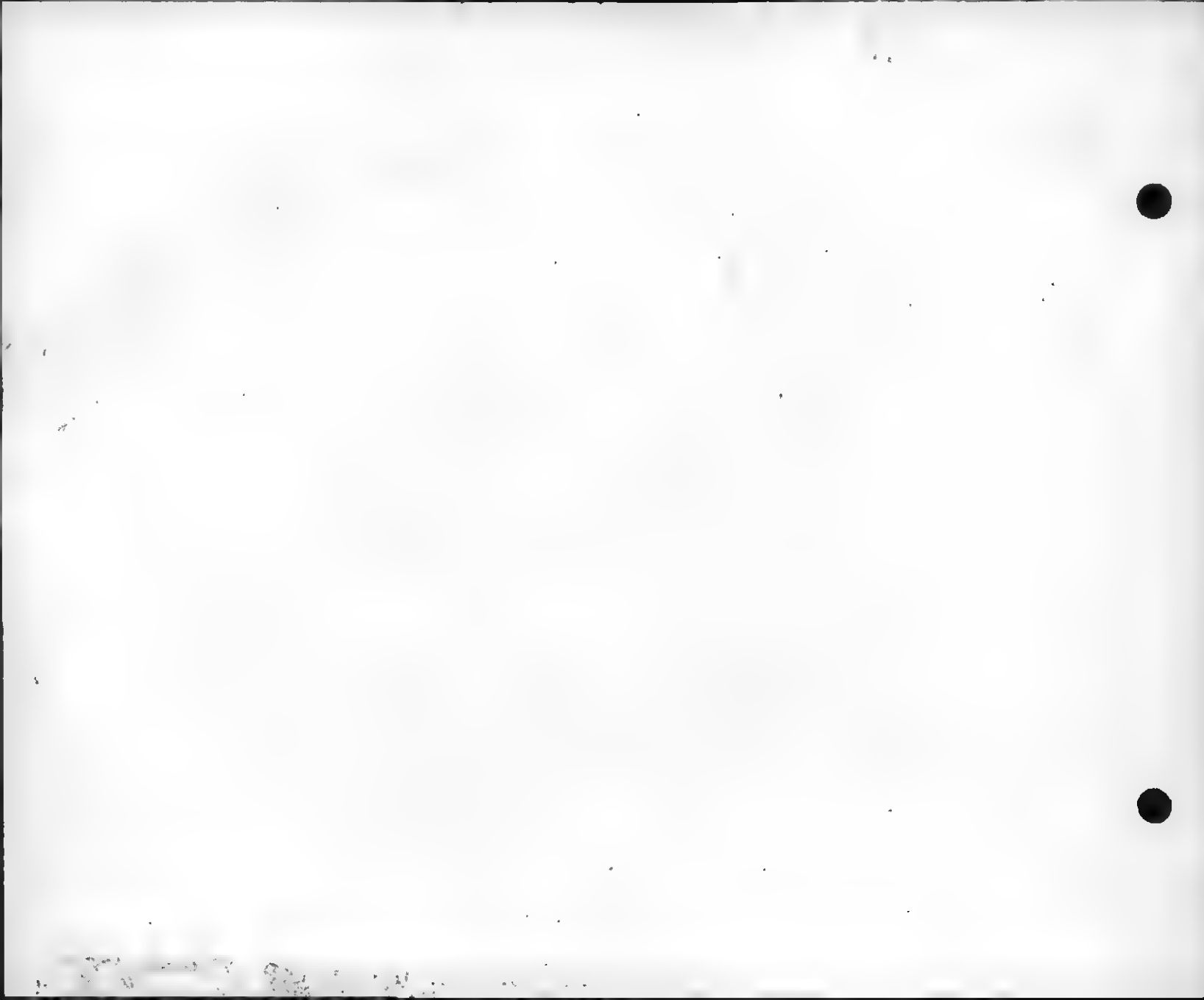
06673

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06671

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
WILLIAM		C.		THOMAS	MAY 18, 1969		10:30 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
MALE	NEGRO		5/25/16		52 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. IF UNDER 24 HRS	
NORTH CAROLINA	U.S.A.				BALTIMORE		MONTHS DAYS HOURS MIN	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		13. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		14. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD		VETERANS ADMIN. HOSPITAL		FARMER		AGRICULTURE		
15a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		15b. COUNTY		16. CITY OR TOWN		17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND				BALTIMORE				
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME		20. STREET AND NUMBER		21. CITY OR TOWN		
KEVIN THOMAS		LAURA McCLOUD		916 WILMOT COURT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
YES WWII		240 20 6118		CLINICAL RECORDS, VAH, FT. HOWARD, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEART FAILURE								
DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE LUNG DISEASE								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from MAY 14, 1969, to MAY 18, 1969, that (2) (we) lost the deceased alive on MAY 18, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above (3) (we) (did) (did not) view the body after death								
22b. SIGNATURE				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		
Peter V. Juvan				5/19/69		PETER V. JUVAN, M. D.		
22e. ADDRESS				22f. ADDRESS				
VAH, FT. HOWARD, MD.				VAH, FT. HOWARD, MD.				
23a. BURIAL (CREMATION or other disposal)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		5-23-69		BALTIMORE NATIONAL		BALTIMORE, MD.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Eugene O. Wilson		WILSON FUNERAL HOME		MAY 20 1969		Charles J. J...		
		2004 Orleans St. Balto. Md.						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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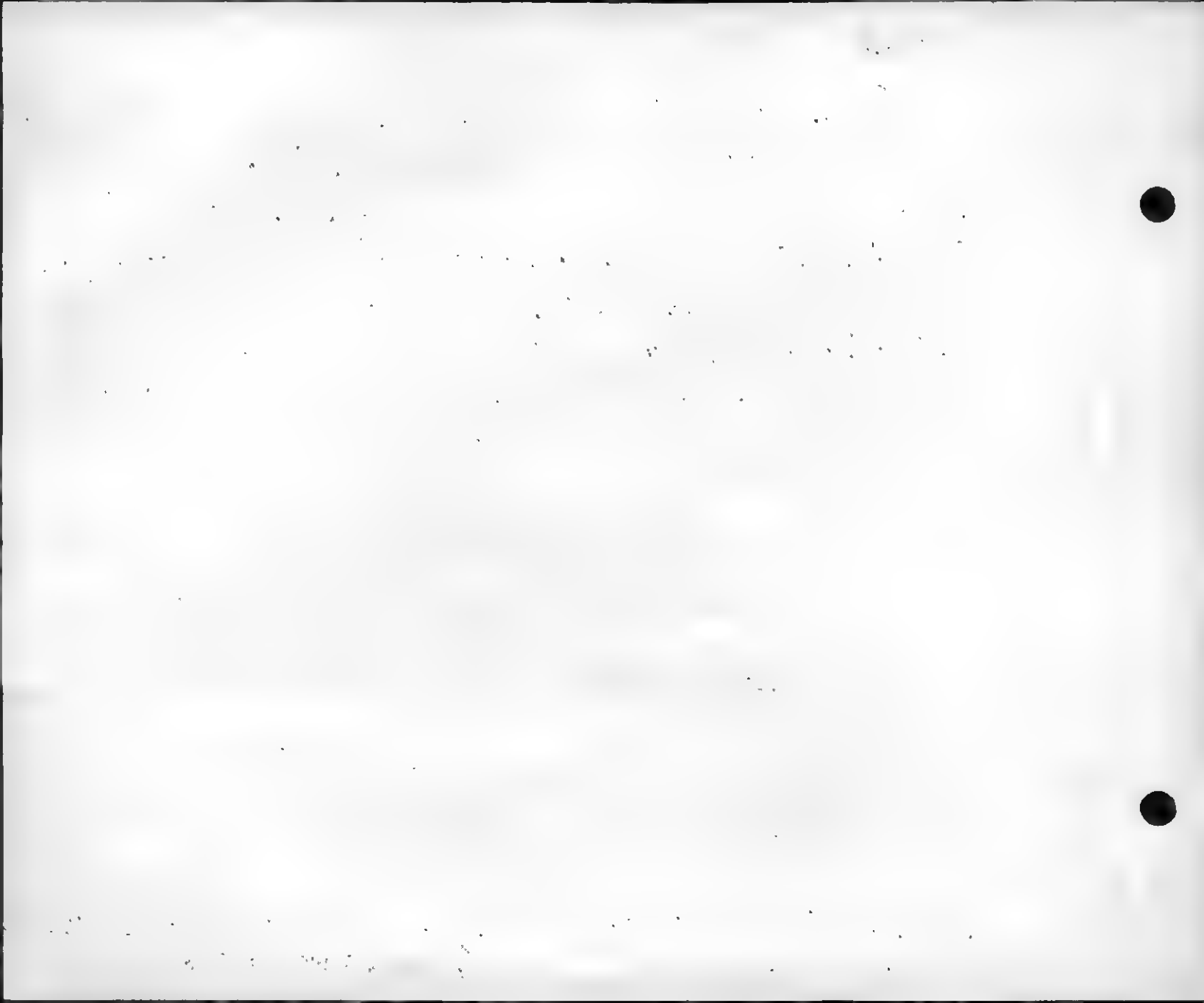
VR 415
30M REV 1-66

06674

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06672

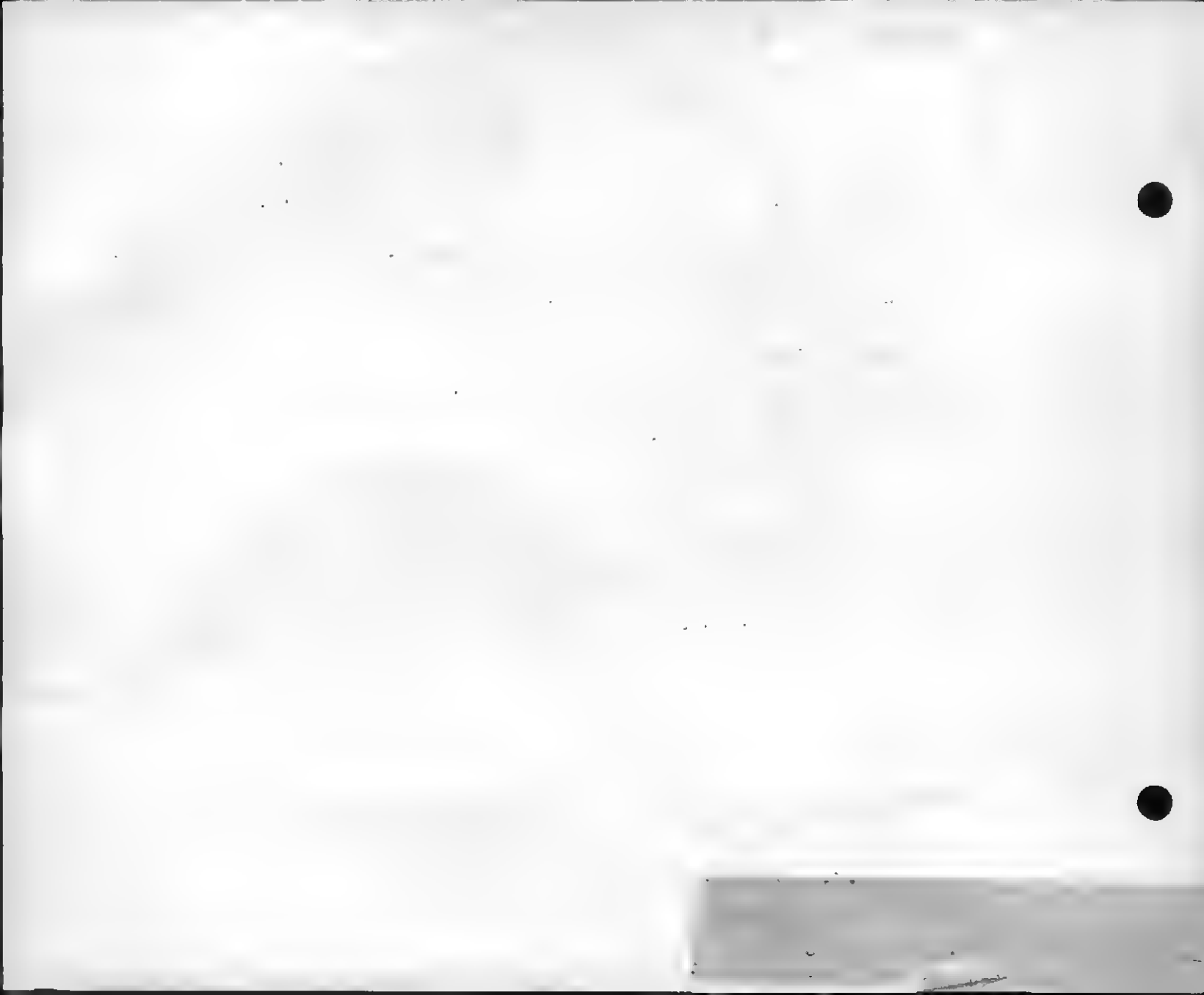
1. DECEASED NAME (Type or print) <u>Stanley M. Thompson</u>			2a. DATE OF DEATH <u>May 14, 1968</u>			2b. HOJR <u>2:30 PM</u>			
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>January 21, 1908</u>		6. AGE (In years last birthday) <u>60</u> YRS		7. IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN	
7a. BIRTHPLACE (State or foreign country) <u>Balto. Co., Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore Co., Md.</u>			
10. CITY OR TOWN OF DEATH <u>Parkton, Md.</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Mt. Carmel Rd.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Trucker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Hauling</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE <u>Md.</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Parkton</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>Mt. Carmel Rd.</u>	
14. FATHER'S NAME First <u>J. Wilmer</u> Middle <u>Thompson</u> Last <u>Thompson</u>			15. MOTHER'S MAIDEN NAME First <u>Annie</u> Middle <u>Mays</u> Last <u>Mays</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>213-14-4737</u>		17. INFORMANT <u>Bernice M. Thompson</u> Address <u>Parkton Md. 2120</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Prostate</u>								<u>5 mo</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>120 X</u>								DUE TO, OR AS A CONSEQUENCE OF	
(c)								DUE TO, OR AS A CONSEQUENCE OF	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <u>3:30</u> AM <u>PM</u> <u>5-14-68</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>68</u> , to <u>May 14</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>May 14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>C. Herbert Mueller</u> M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5-14-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER JR.</u>				22e. ADDRESS <u>PARKTON Md. 2120</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>May 17, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Heretford Baptist</u>		23d. LOCATION (City or Town) (County) (State) <u>Parkton Balto. Co., Md.</u>			
24. FUNERAL DIRECTOR <u>James Starbuck</u>		ADDRESS <u>New Freedom Pa.</u>		25a. REC'D BY REGISTRAR <u></u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
				DATE <u>MAY 21 1968</u>					



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06675		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06673	
1. DECEASED NAME			2a. DATE OF DEATH		2b. HOUR
First	Middle	Last	Month	Day	Year
HARVARD CLARK TOWNSEND			5	19	69
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)
MALE		Caucasian	November 25, 1895		73 YRS
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maine	U.S.A.			BALTIMORE Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
TOWSON		GREATER BALTO. MED. CNR.		Engineer Western Electric	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland		Baltimore	Riderwood	YES <input type="checkbox"/> NO <input type="checkbox"/>	7924 Springway Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
First Middle Last Willis S. Townsend			First Middle Last Nantie Clark		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.	17. INFORMANT Address #		
Yes		W. W. One	Mrs. Helen Marie Townsend, Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION					DAYS
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) CANCER OF THE PANCREATIC BODY					MONTHS
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
5/16/69		EXPLORATORY LAP; CYSTOJEJUNOSTOMY		NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/11, 1969, to 5/19, 1969, that (I) (we) last saw the deceased alive on 5/19, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Richard L. Smith M.D.		M.D.		5/19 69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
RICHARD L. SMITH, M.D.		6701 N. CHARLES ST., BALTO. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)
Burial		5-22-1969	Clarendon Hills Cemetery		Downers Grove, Illinois
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Wm. Cook-Brooks Towson,		1050 York Road Towson, Maryland 21204		20 1969	



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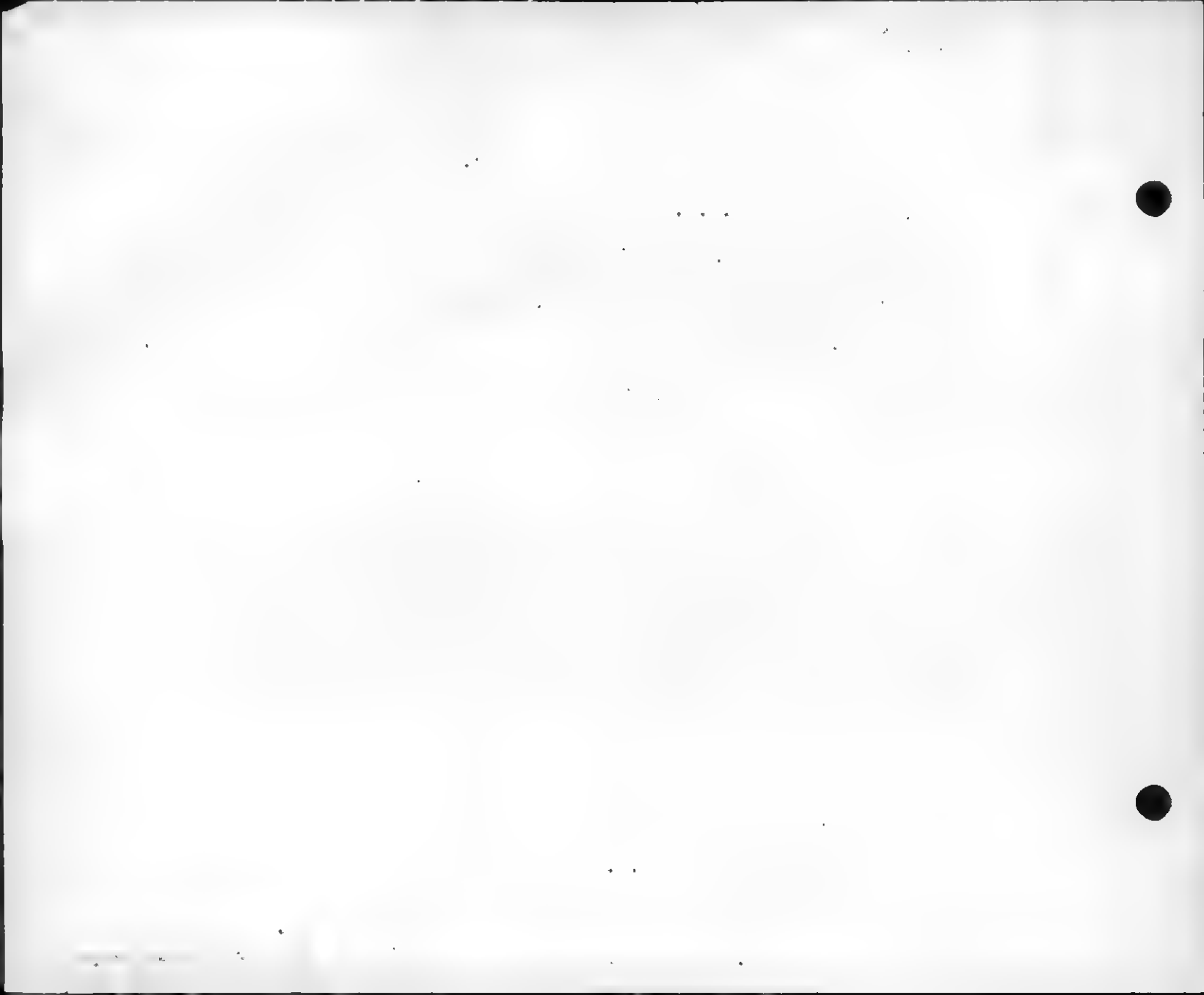
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06676

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06674

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P. M.	
Wilmer			C	Tracey	May 19 69		9:15 P. M.	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Male	White		Dec. 22, 1893		75 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. KIND OF BUSINESS OR INDUSTRY	
Maryland	U.S.A.				Baltimore		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Parkville		2908 Taylor Ave		Air Conditioning Retired				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland		Baltimore		Parkville		2908 Taylor Ave		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		17. INFORMANT		
Alfred		Tracey		Nancy		Cooper		
16a. YES, NO, OR UNKNOWN		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		213-05-1851		Mrs Henrietta C Tracey		Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4379</u> <u>Bronchopneumonia</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Central arteriosclerosis</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 years</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>64</u> , to <u>May 19</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 19</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
<u>R Donald Jandorf</u>		5-21-69		R Donald Jandorf M.D.				
22e. ADDRESS		22f. ADDRESS						
7403 Harford Rd Baltimore, Maryland		7403 Harford Rd Baltimore, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5/22/69		Moreland Memorial Park		Baltimore, Maryland		
24. FUNERAL DIRECTOR		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		
Leonard J Ruck Inc. Baltimore, Maryland		MAY 21 1969		<u>John J. Judge</u>				



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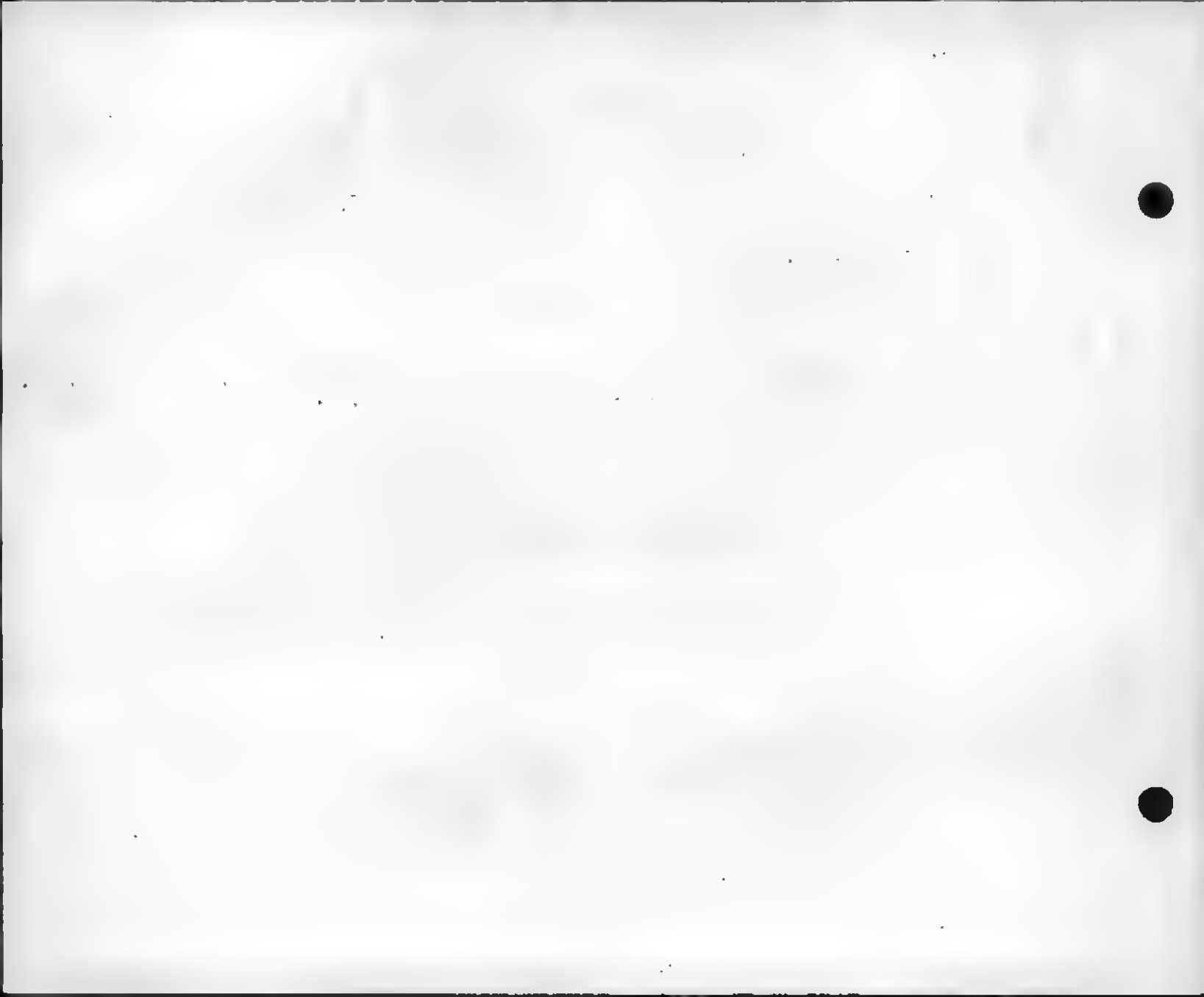
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06677					06675					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					
First Middle Last PATRICIA ANN TURNER					Month Day Year 5 27 1969					
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7b. HOUR		
Female		Caucasian		6/14/44		29 YRS		6:00pM		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MD.		USA				Baltimore Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Towson, MD.			Greater Balto. Med. Center			HOUSEWIFE				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
MD			BALTO		ESSEX		YES		5 FLORAL PLACE	
14 FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last					
MILTON RAILEY					GLORIA JENKINS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT			Address		
UNK					FRANK TURNER			ABOVE		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized metastasis from carcinoma of lung										
1621 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause										
DUE TO, OR AS A CONSEQUENCE OF										
last (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 5/24, 1969, to 5/27, 1969, that (I) (we) last saw the deceased alive on 5/27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Charles C. Brown, M.D.					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED May 28, 1969			
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M. D.					22e ADDRESS Greater Baltimore Medical Center					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
BURIAL		5/31/69		DULANEY VALLEY		BALTO. MD.				
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE			
Connelly 300 Race Ave					JUN 3 1969		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) CORNELIUS DOWNER VAN VORST			First Middle Last			2a. DATE OF DEATH Month 5 Day 3 Year 69			2b. HOUR 8:30 AM		
3. SEX male			4. RACE white			5. DATE OF BIRTH Jan 2, 1878			6. AGE (In years last birthday) 91 YRS		
7a. BIRTHPLACE (State or foreign country) N.J.			7b. CIT ZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Catonsville, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) textile			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md			13b. COUNTY Balto			13c. CITY OR TOWN Catonsville			13d. INS DE CITY LIM TSP YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 204 Bloomsbury Ave			14. FATHER'S NAME First Middle Last Garrett Van Vorst			15. MOTHER'S MAIDEN NAME First Middle Last Hadden Unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) () yes give war or dates of service No		
16b. SOCIAL SECURITY NO 217-12-6028			17. INFORMANT 204 Bloomsbury Ave, Catonsville, Md. Chas. C. W. Van Vorst 21228			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIOVASC DISC UNKNOWN DUE TO, OR AS A CONSEQUENCE OF (c) AGE PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/10, 1969 to 5/3, 1969 , that (I) (we) last saw the deceased alive on 5/1, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Cliff Ratliff, Jr.			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/3/69		
22d. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.			22e. ADDRESS 4605 EDMONDSON AVE BALTO								
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal - Burial			23b. DATE 5/6/1969			23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery			23d. LOCATION (City or Town) (County) (State) Fairview, New Jersey		
24. FUNERAL DIRECTOR Easton Funeral Home Catonsville			ADDRESS Catonsville			25a. REC'D BY REGISTRAR DATE MAY 6 1969			25b. REGISTRAR'S SIGNATURE Charles J. [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06679

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06677

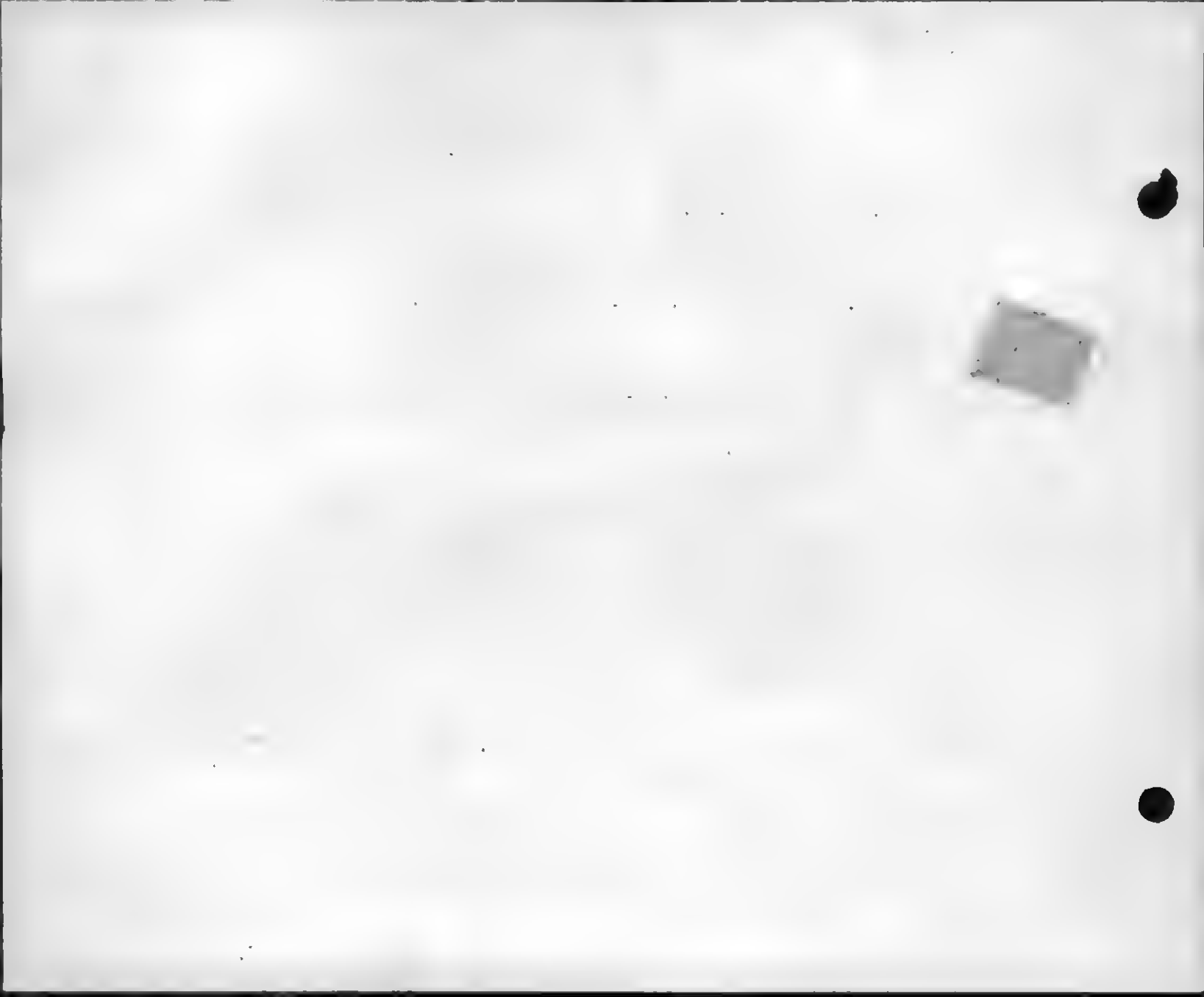
1 DECEASED NAME (Type or print)		First Esther		Middle Mae		Last VIERKORN		2a DATE OF DEATH Month 5 Day 5 Year 63			2b HOUR 11:45 AM				
3 SEX Female		4 RACE White		5. DATE OF BIRTH Feb. 14, 1917			6 AGE (In years last birthday) 42 YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN				
7a BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md									
10 CITY OR TOWN OF DEATH Owings Mills		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Rosewood State Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none			12b KIND OF BUSINESS OR INDUSTRY none								
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Prince Geo.		13c CITY OR TOWN Lanham		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5501 Whitfield Chapel Rd.							
14. FATHER'S NAME		First Stephen		Middle Leo		Last Vierkorn		15 MOTHER'S MAIDEN NAME		First Esther		Middle May		Last KAEGLER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. none		17 INFORMANT Rosewood Records, Owings Mills, Md. 21117											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 hours				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>11/8</u> , 19 <u>61</u> , to <u>5/5</u> , 19 <u>63</u> , that (I) (we) last saw the deceased alive on <u>5/5</u> , 19 <u>63</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE 								DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 5/5/69					
22d PHYSICIAN'S NAME (Type) N. Turkman, M.D.		22e ADDRESS Rosewood State Hospital, Owings Mills													
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/7/69		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.									
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 9 1969		25b REGISTRAR'S SIGNATURE 									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06680						06678					
1 DECEASED-NAME (Type or print) GEORGE H. WALLACE						2a. DATE OF DEATH Month 5 Day 19 Year 1969 2b. HOUR 3:00 P.M.					
3 SEX male			4 RACE Negro			5 DATE OF BIRTH Dec. 31, 1896			6 AGE (In years lost, birthday) 72 YRS		
7a BIRTHPLACE (State or foreign country) Penn.			7b CITIZEN OF WHAT COUNTRY? U. S.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore		
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) SPRING GROVE STATE HOSP.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) postal worker			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b CITY OR TOWN Pr. Geo.			13c INSIDE CITY U.M. 1ST <input type="checkbox"/> NO <input type="checkbox"/>			13d STREET AND NUMBER 6605 "K" Street		
14 FATHER'S NAME First Edward Middle Last 						15 MOTHER'S MAIDEN NAME First Laura Middle Last 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			16b SOCIAL SECURITY NO 213-42-7361M			17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA										WEEKS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										(b) 	
(c) 										(d) 	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS - DEHYDRATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from Oct. 18 , 19 68 , to May 19 , 19 69 , that (X) (we) last saw the deceased alive on MAY 19, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Alberto M. Gutierrez						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 5-19-69		
22d. PHYSICIAN'S NAME (Type) ALBERTO M. GUTIERREZ, MD						22e. ADDRESS SPRING GROVE STATE HOSPITAL					
23a. BURIAL, CREMATION, or other disposal Burial			23b. DATE 5/26/69			23c. NAME OF CEMETERY OR CREMATORY NE			23d. LOCATION (City or Town) (County) (State) Philadelphia, Pa.		
24. FUNERAL DIRECTOR STEWART						25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06681
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item 5 Film G412 5/8/69 kk
CERTIFICATE OF DEATH

06679

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P.		
Marie		T.		Walter	May 3 1969		4:00 PM		
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female	White		2-12-96 1897		72 YRS				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Virginia	USA				Baltimore		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					
Baltimore		St. Joseph Hospital		Homemaker					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Baltimore		YES		3116 Berkshire Rd. #21214	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
James		Fagan		Margaretta ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
NO		212-09-2091B		husband - Louis F. Walter (same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction									
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5-3-69, 19 69, to 5-3-69, 19 69, that (I) (we) last saw the deceased alive on 5-3-69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Camilo Tomboc, M.D.						5-3-69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
				7620 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/7/69.		Holy Redeemer Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc. Balto. Md. 21214				MAY 5 1969		Charles Judge			

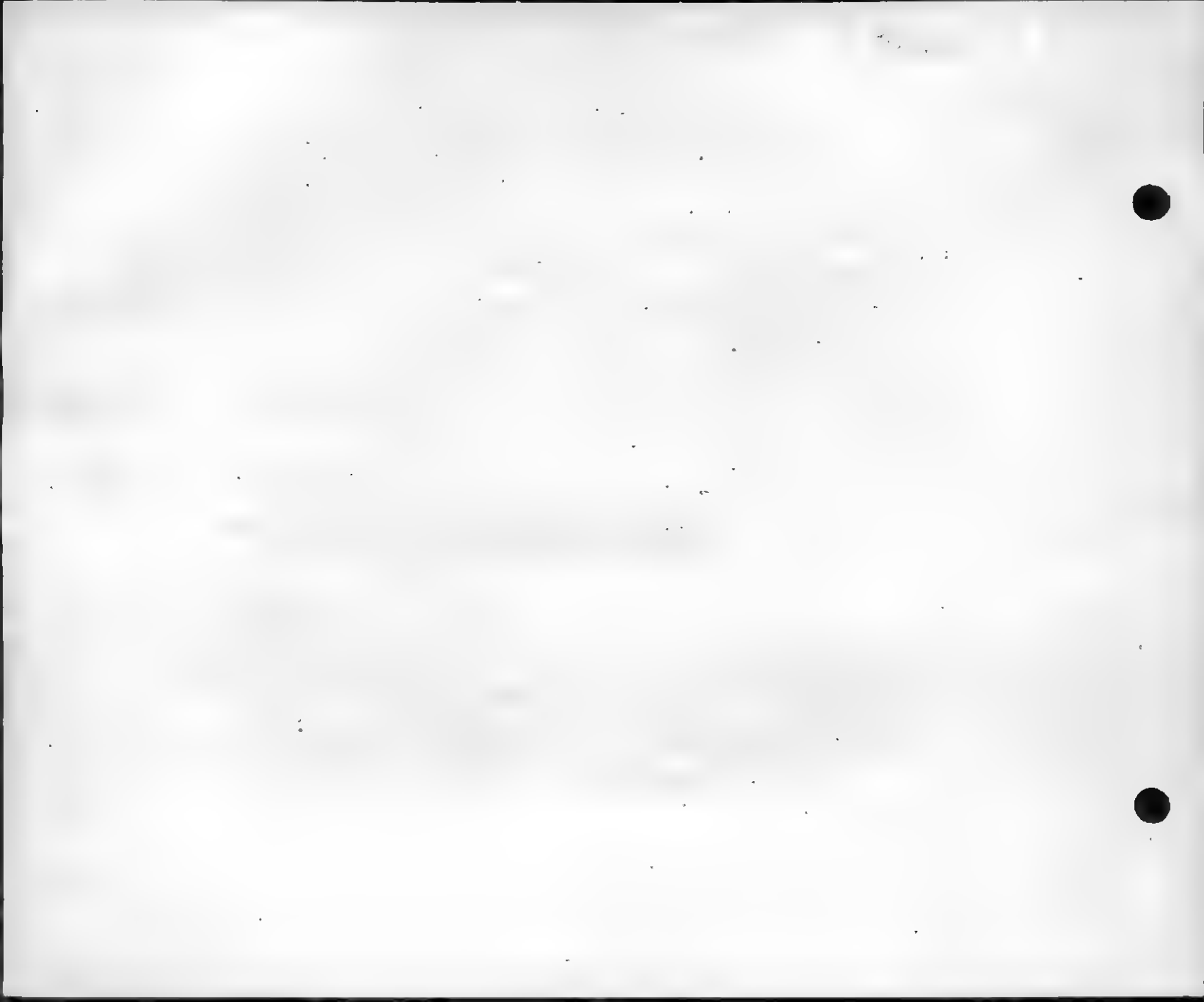


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304 REV 11/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)		First THERESA		Middle LILLIAN		Last WALTERS		2a. DATE OF DEATH Month Day Year May 11, 1969		2b. HOUR 5 p.m.
3. SEX female		4. RACE white		5. DATE OF BIRTH 7/11/1903		6. AGE (In years last birthday) 65		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 808 Mockingbird Lane		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 808 Mockingbird Lane		21204
14. FATHER'S NAME First Middle Last Frank E. Palcher				15. MOTHER'S MAIDEN NAME First Middle Last Mary Puskar						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 215-03-8308B		17. INFORMANT Robert Walters, husband, above		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYO CARDIAL INFARCTION</u>										3 MCS
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 11, 1969</u> , to <u>MAY 11, 1969</u> , that (I) (we) last saw the deceased alive on <u>MAY 10, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <u>T. C. Siwinski</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>13 MAY 69</u>		
22d. PHYSICIAN'S NAME (Type) Dr. Thaddeus C. Siwinski				22e. ADDRESS 206 W. Pennsylvania Ave.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/15/69		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.				25a. REC'D BY REGISTRAR MAY 15 1969		25b. REGISTRAR'S SIGNATURE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

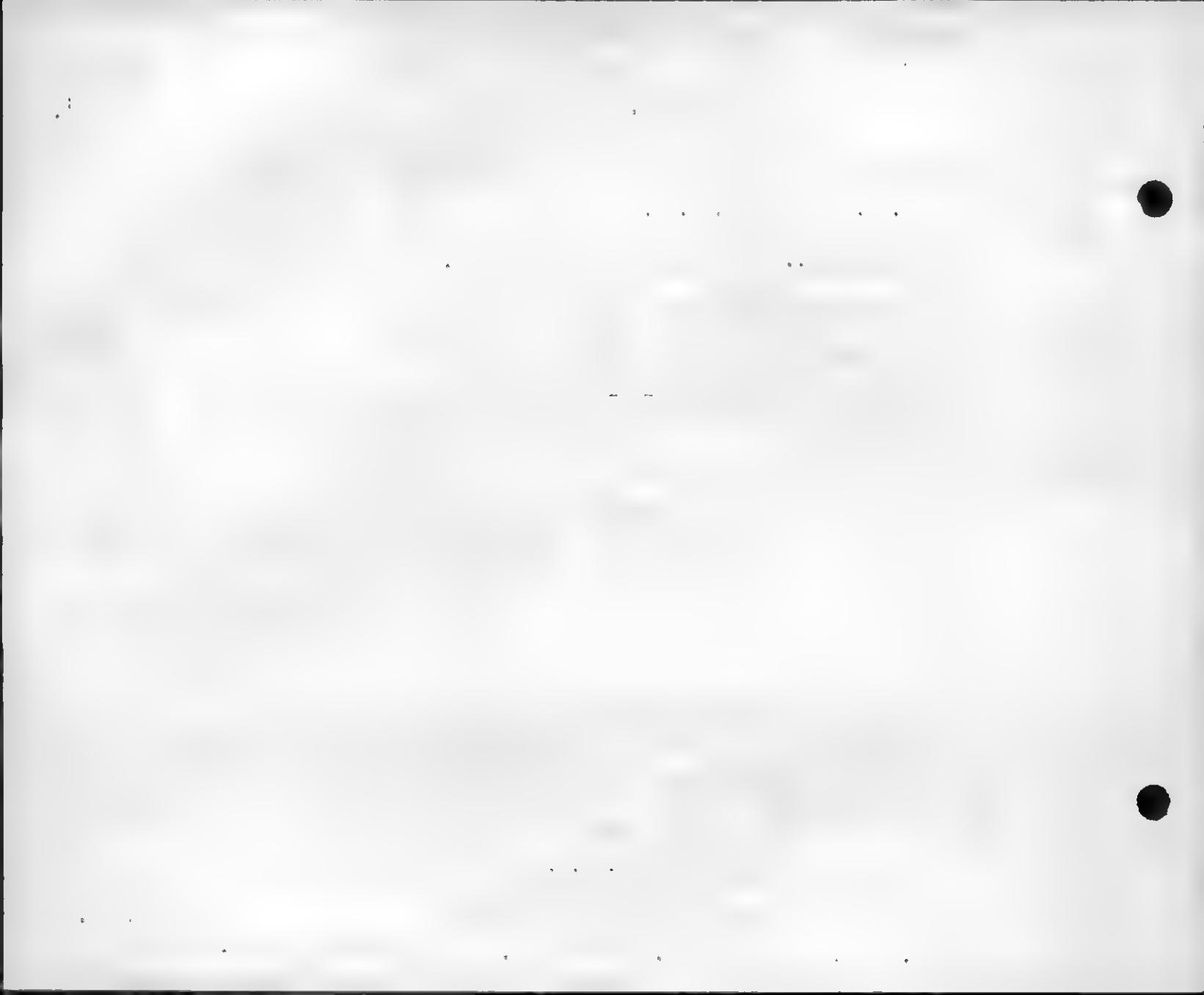
06683

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06681

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. H.O. JR. M	
Ada		A.		Wampler	May 28, 1969		4:55	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	White		5/1/1891		78 YRS			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
	U. S. A.				Baltimore County Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville, Md.		Spring Grove State Hosp.		Retired clerk				
13a. USUAL RESIDENCE (Where deceased lived, if institutional an admission) STATE		13b. CITY OR TOWN		13c. US-DE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6713 York Road		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
William Wasch		Catherine Zink						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No		213-14-4559-A		Records--Spring Grove State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral bronchopneumonia.								48 hrs
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
DUE TO, OR AS A CONSEQUENCE OF								
(b)								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
A.S.C.V.D.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from 4/3/69, 19, to May 28, 1969, that (1) (we) last saw the deceased alive on 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
Diomidis Pirovolidis		5-28-69						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Diomidis Pirovolidis, M.D.		Spring Grove State Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5/31/69		Loudon Park Cemetery		Baltimore, Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG. STAFF		25b. REGISTRAR'S SIGNATURE		
John J. Duda, 7922 Wise Ave.		Dundalk, Md.		JUN 2 1969		M. J. Duda		



MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE
HEALTH DEPT.

06684

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06682

1 DECEASED NAME (Type or Print) Edward J. Ward			2a DATE KNOWN OF DEATH Month 5 Day 28 Year 1969			2b HOUR ? M		
3 SEX M	4 RACE W	5 DATE OF BIRTH Aug. 8, 1906	6 AGE (In years last birthday) 62 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 0 MIN	2c DATE PRONOUNCED DEAD Month 5 Day 30 Year 1969		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md		
10 CITY OR TOWN OF DEATH Dundalk		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 104 Baltimore Ave.			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Welder		2b KIND OF BUSINESS OR INDUSTRY Steel	
3a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First Frank Middle Ward Last Ward			15 MOTHER'S MAIDEN NAME First Leila Middle Renner Last Renner			3e STREET AND NUMBER 104 Baltimore Ave.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		6b SOCIAL SECURITY NO (If yes, give war or dates of service) 214-01-8389		17 INFORMANT Aunt: Cora E. Barker		ADDRESS 2808 Kings Ridge Apt. D Parkville Md. 17201		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Gastric Bleeding DUE TO, OR AS A CONSEQUENCE OF (b) Chronic alcoholism DUE TO, OR AS A CONSEQUENCE OF (c) Chronic L.E. (Syphilis) Skin								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Theoc Patterson			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 5/3/69		
EXAMINER'S NAME (Type) THEOC PATTERSON			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION OR REMOVAL (Specify) Burial			23b DATE June 2, 1969		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d LOCATION (City or Town) (County) (State) Baltimore Maryland	
24 FUNERAL DIRECTOR John J. Duda			ADDRESS 7922 Wise Ave. Balt. Md. 21222			25a. REC'D BY REG STRAR DATE JUN 3 1969		25b REGISTRAR'S SIGNATURE Charles Judge

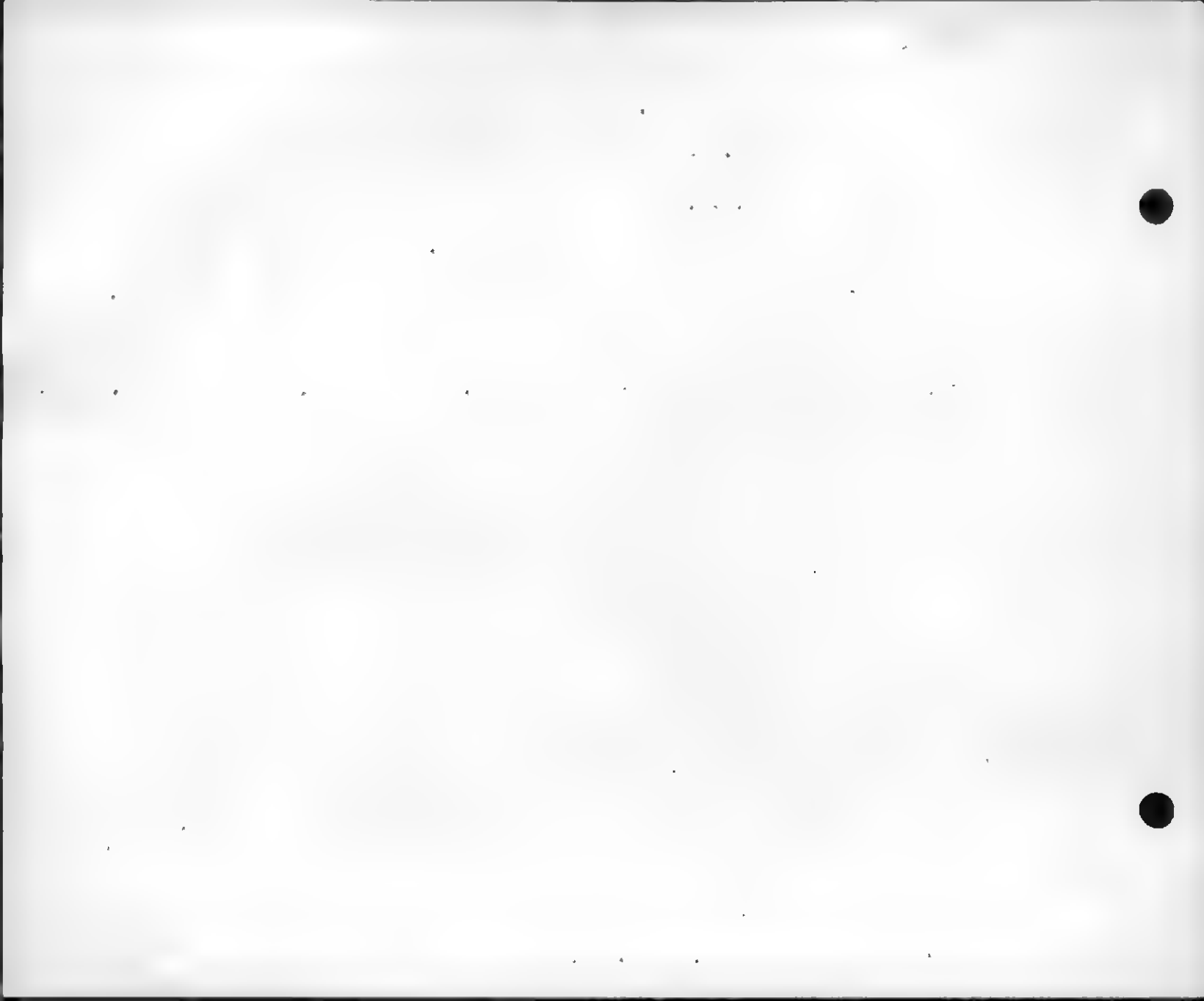
MEDICAL CERTIFICATION ON

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

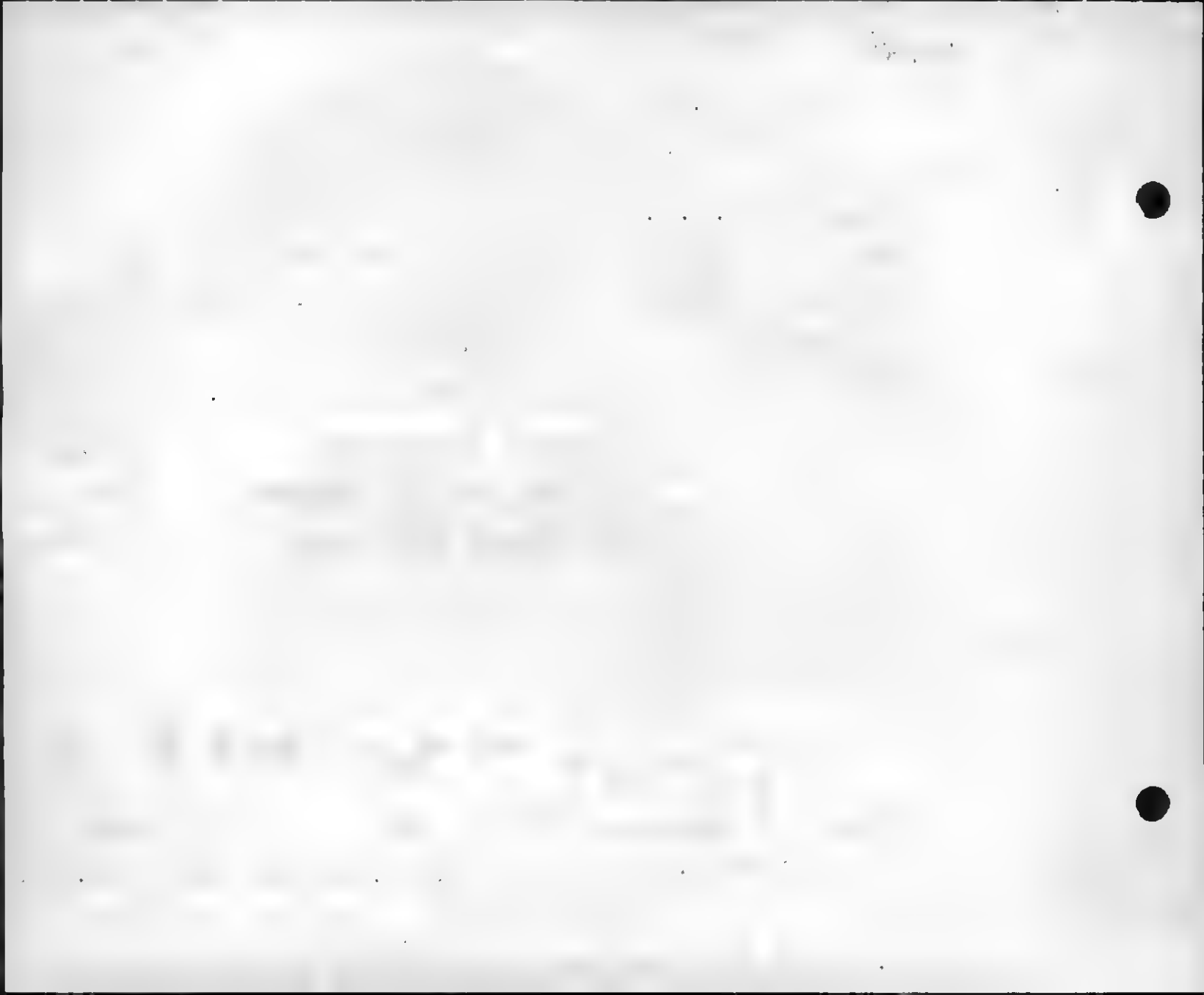
VR A15ME
10M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>06685</div> <div> <div>DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06683</div> </div>																
1. DECEASED-NAME (Type or print)			First GEORGE			Middle H.			Last WEBER			2a. DATE OF DEATH: Month Day Year May 21 1969			2b. HOUR M	
3. SEX Male			4. RACE White			5. DATE OF BIRTH 1-5-1902			6. AGE (In years lost birthday) 67 YRS			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CIT. ZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md				
10. CITY OR TOWN OF DEATH Arbutus			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1054 Downton Road			12a. USUAL OCCUPATION (Kind of work done during last or working life, even if retired) Glass Blower			12b. KIND OF BUSINESS OR INDUSTRY Glad's							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Arbutus			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 1054 Downton Road 21227				
14. FATHER'S NAME First Middle Last John Weber						15. MOTHER'S MAIDEN NAME First Middle Last Mary Beck										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 215-16-5886			17. INFORMANT Address Mamie Weber 1054 Downton Rd. Arbutus 21227										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 4-1-69 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>High blood pressure</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 years</u> <u>17 years</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF DEATH HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 29, 1947</u> to <u>May 20, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 20, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Gilbert E. Rudman M.D.</u>						22c. DATE SIGNED <u>5/22/69</u>			22d. PHYSICIAN'S NAME (Type) Dr. Gilbert E. Rudman							
22e. ADDRESS 2517 W. Baltimore Street, Balto., Md.																
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5-24-69			23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore City, Maryland							
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229						25a. REC'D BY REGISTRAR DATE MAY 23 1969			25b. REGISTRAR'S SIGNATURE <u>R. Charles Judge</u>							

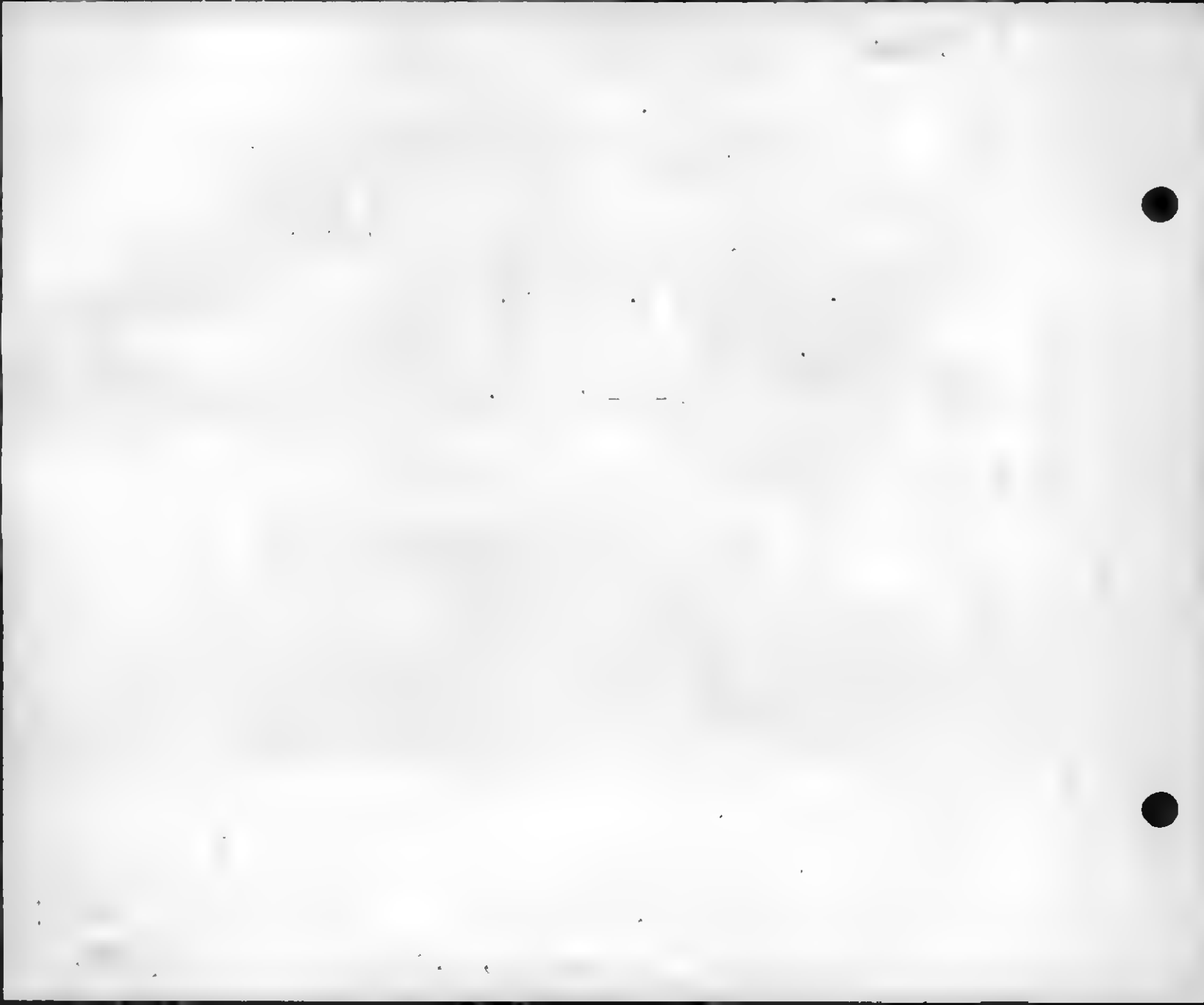


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-8. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

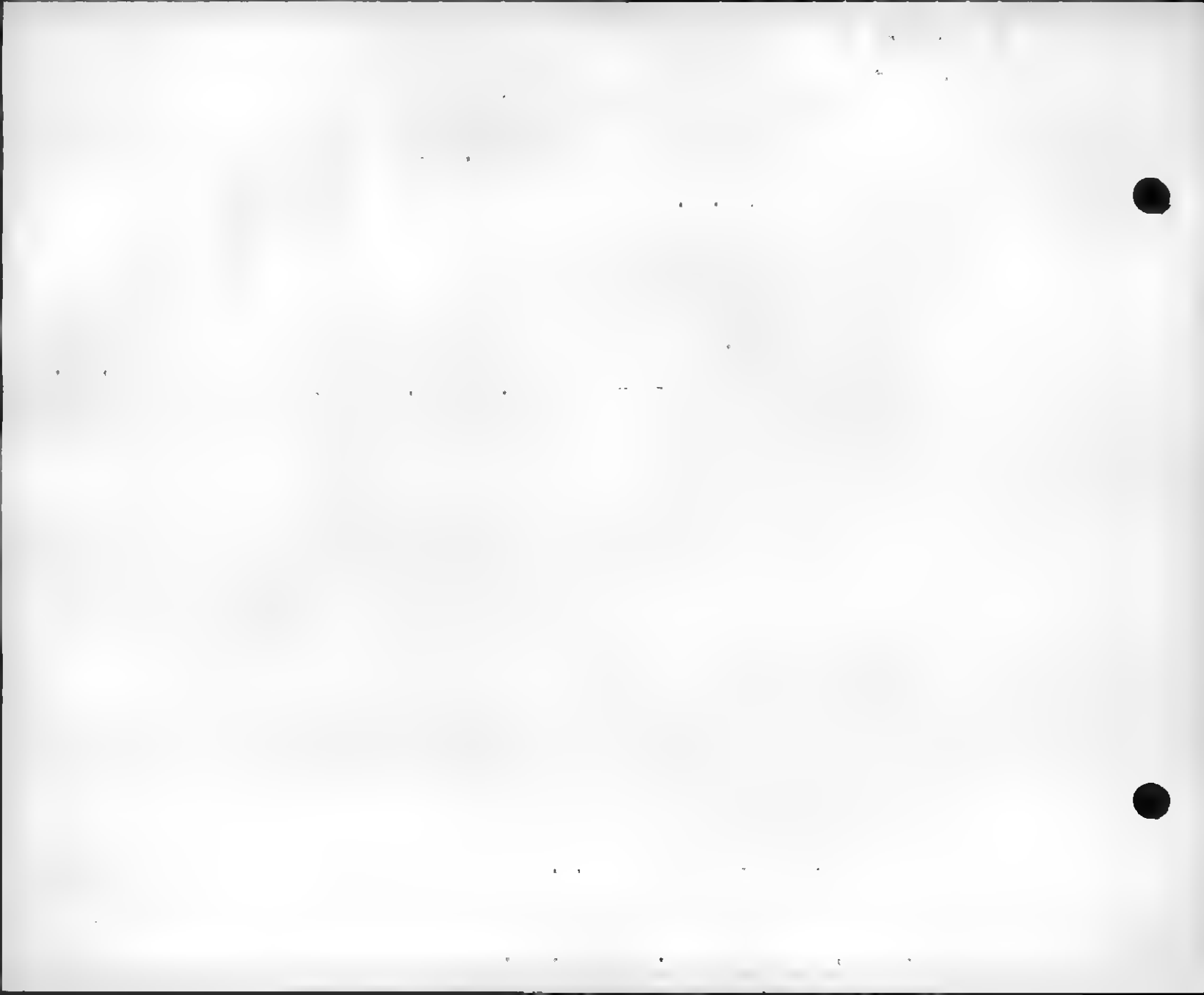
<div>06686</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>06684</div>									
1 DECEASED-NAME (Type or Print) Dorothea			First Middle Last E. Wehland			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5 16 1969		2b HOUR M	
3 SEX F	4 RACE W	5. DATE OF BIRTH 3 17 99	6 AGE (In years last birthday) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month 5 Day 19 Year 1969		2d HOUR 1730 M	
7a. BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md	
10 CITY OR TOWN OF DEATH Lansdown		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 1926 Sulphur Spring Road		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic housekeeping & Baby sitting		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE MD.		13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 1926 Sulphur Spring Rd	
14 FATHER'S NAME First Middle Last Henry R. Wehland				15. MOTHER'S MAIDEN NAME First Middle Last Friederike Rhode					
16a WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If yes give year or dates of service) 218-424-137		17 INFORMANT ADDRESS H05 4958 Mrs. Shirley Carter Ellicott City					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 4124 IMMEDIATE CAUSE (a) A CVH D DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Osteoarthritis									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John F. Schaefer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 5 19 69			
EXAMINER'S NAME (Type) John F. Schaefer M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) 401 Random Rd. - 21229			
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE 5/22/1969		23c NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d LOCATION (City or Town) (County) (State) Pfeiffer's Corner Howard Co., Md.			
24 FUNERAL DIRECTOR Easton Funeral Home				ADDRESS Catonsville, Md.		25a REC'D BY REG STRAR MAY 26 1969		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06687		CERTIFICATE OF DEATH						06685		
1. DECEASED NAME (Type or print) Susan			First Middle Last Weinberger			2a. DATE OF DEATH Month May Day 14 , Year 1969			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 22, 1888			6. AGE (In years lost birthday) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Dundalk			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 2634 Liberty Parkway			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland			13b. CITY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER 2634 Liberty Parkway	
14. FATHER'S NAME First John Middle H. Last Keller			15. MOTHER'S MAIDEN NAME First Louise Middle Waltzen			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)				
16b. SOC AL SECURITY NO 220-46-0984			17. INFORMANT (Daughter) Mrs. Edna M. Bowers, 2634 Liberty Parkway			Address Dundalk, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sen Kemia Chronic 70% DUE TO, OR AS A CONSEQUENCE OF (b) H Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HFCVD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. COND-T ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 8-14 , 19 68 , to 5/10 , 19 69 , that (I) (we) last saw the deceased alive on 5/10 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Theodore C. Patterson				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/14/69				
22d. PHYSICIAN'S NAME (Type) Theodore C. Patterson M.D.				22e. ADDRESS 3427 Dundalk Ave. Balt. Md 22						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/17/69		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE MAY 19 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				



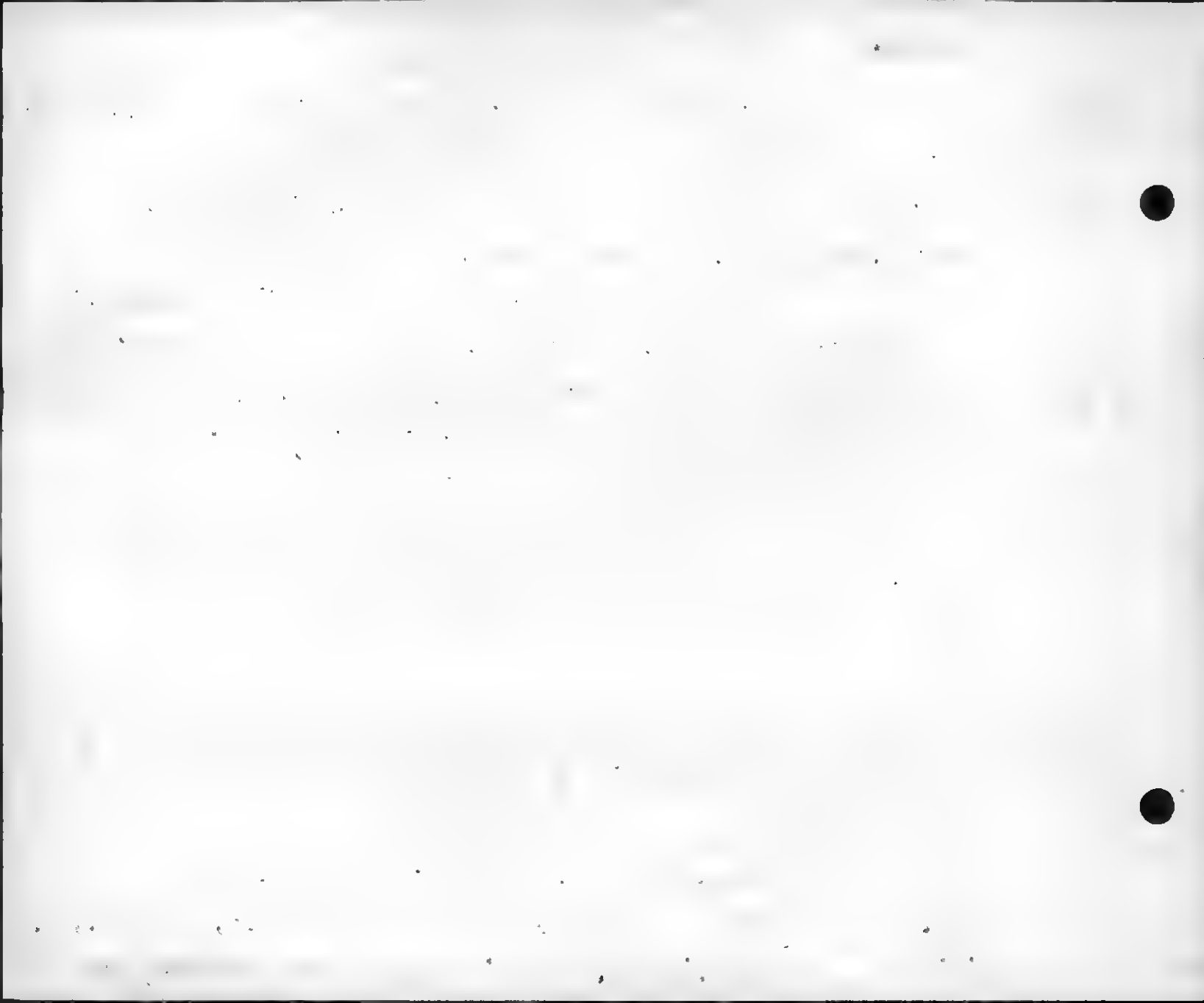
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-44
304M REV. 1-78

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) MIRIAM			First — Middle — Last WELCH			2a. DATE OF DEATH Month MAY Day 31 Year 1969			2b. HOUR 10:30 AM		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 11/5/90			6. AGE (In years lost birthday) 78 YRS.		
7a. BIRTHPLACE (State or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore County, Md.		
10. CITY OR TOWN OF DEATH Mount Wilson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SECRETARY			12b. KIND OF BUSINESS OR INDUSTRY CHEMICAL		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY BALTO.			13c. CITY OR TOWN BALTO.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First ROBERT M Middle — Last WELCH			15. MOTHER'S MAIDEN NAME First ELIZABETH Middle W Last SPENCER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give year or dates of service)			16b. SOCIAL SECURITY NO 215-01-1963			17. INFORMANT Address Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM, DUE TO DECOMPOSING ULCEBRATIONS 450X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) — DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) —											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that the (this hospital) attended the deceased from 23 MAY, 1969 to 31 MAY, 1969 , that we (we) lost the deceased on 31 MAY, 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, we (we) (did) (did not) view the body after death.											
22b. SIGNATURE William Newcomer			DEGREE — ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 5/31/69					
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.			22e. ADDRESS Mount Wilson, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6/4/1969			23c. NAME OF CEMETERY OR CREMATORY Druid Ridge			23d. LOCATION (City or Town) (County) (State) Pikesville, BaltoCo., Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.						25a. REC'D BY REGISTRAR JUN 2 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

06689

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06687

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year		2b HOUR
LENA		WESTPHALE			May 23, 1969		9:45A
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	2/5/99	70 YRS			May 23, 1969	9:45A
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md	
Maryland	U.S.A.			Baltimore			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Baltimore	8101 Clyde Bank Rd.		Clerk		Grocery Store		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER			
Maryland	Baltimore			8101 Clyde Bank Road			
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last
			Schmidt				Unknown
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS			
No		218-32-0334		Viola L. Ruppert - 8101 Clyde Bank Rd			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism							
450X DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
Arteriosclerotic cardiovascular disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		5/23/69	
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		5/26/69	Moreland Memorial Pk.		Baltimore, Maryland		
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Robert C. Altenburg Funeral Home, Inc.		6009 Harford Rd. - Balto., Md. 21214		MAY 27 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1A

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Joseph		Franklin		Wheeler				Month 5 Day 4 Year 69		1:15 P.M.	
3 SEX		4. RACE		5 DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		W		Nov. 14 1874		74 YRS		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA				BALTIMORE					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
CATONSVILLE		HOUSE IN PINES		CARPENTER		CONSTRUCTION					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD		HOWARD		JESSUP		YES <input type="checkbox"/> NO <input type="checkbox"/>		4215 MISSION RD			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
NATHANIEL		WHEELER						Sarah		Murray	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
				28-05-356		JOSEPH A. WHEELER		JESSUP MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Arteriosclerotic Cardio-Vascular Disease											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b. TIME OF INJURY HOUR A.M. Month Day Year 19											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)											
21f. LOCATION Street or RFD No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 10-31-1968, to 5-4-1969, that (I) (we) last saw the deceased alive on 5-2-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE											
22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, M.D.											
22e. ADDRESS 6209 Frederick Ave. Balt., Md. 21228											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City or Town) (County) (State)											
24. FUNERAL DIRECTOR											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											
26. BURIAL, CREMATION, REMOVAL (Specify)											
26b. DATE											
26c. NAME OF CEMETERY OR CREMATORY											
26d. LOCATION (City or Town) (County) (State)											
27. FUNERAL DIRECTOR											
27b. DATE											
27c. NAME OF CEMETERY OR CREMATORY											
27d. LOCATION (City or Town) (County) (State)											
28. FUNERAL DIRECTOR											
28b. DATE											
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28d. LOCATION (City or Town) (County) (State)											
29. FUNERAL DIRECTOR											
29b. DATE											
29c. NAME OF CEMETERY OR CREMATORY											
29d. LOCATION (City or Town) (County) (State)											
30. FUNERAL DIRECTOR											
30b. DATE											
30c. NAME OF CEMETERY OR CREMATORY											
30d. LOCATION (City or Town) (County) (State)											
31. FUNERAL DIRECTOR											
31b. DATE											
31c. NAME OF CEMETERY OR CREMATORY											
31d. LOCATION (City or Town) (County) (State)											
32. FUNERAL DIRECTOR											
32b. DATE											
32c. NAME OF CEMETERY OR CREMATORY											
32d. LOCATION (City or Town) (County) (State)											
33. FUNERAL DIRECTOR											
33b. DATE											
33c. NAME OF CEMETERY OR CREMATORY											
33d. LOCATION (City or Town) (County) (State)											
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34b. DATE											
34c. NAME OF CEMETERY OR CREMATORY											
34d. LOCATION (City or Town) (County) (State)											
35. FUNERAL DIRECTOR											
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35c. NAME OF CEMETERY OR CREMATORY											
35d. LOCATION (City or Town) (County) (State)											
36. FUNERAL DIRECTOR											
36b. DATE											
36c. NAME OF CEMETERY OR CREMATORY											
36d. LOCATION (City or Town) (County) (State)											
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37d. LOCATION (City or Town) (County) (State)											
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80d. LOCATION (City or Town) (County) (State)											
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81c. NAME OF CEMETERY OR CREMATORY											
81d. LOCATION (City or Town) (County) (State)											
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82c. NAME OF CEMETERY OR CREMATORY											
82d. LOCATION (City or Town) (County) (State)											
83. FUNERAL DIRECTOR											
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83c. NAME OF CEMETERY OR CREMATORY											
83d. LOCATION (City or Town) (County) (State)											
84. FUNERAL DIRECTOR											
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84d. LOCATION (City or Town) (County) (State)											
85. FUNERAL DIRECTOR											
85b. DATE											
85c. NAME OF CEMETERY OR CREMATORY											
85d. LOCATION (City or Town) (County) (State)											
86. FUNERAL DIRECTOR											
86b. DATE											
86c. NAME OF CEMETERY OR CREMATORY											
86d. LOCATION (City or Town) (County) (State)											
87. FUNERAL DIRECTOR											
87b. DATE											
87c. NAME OF CEMETERY OR CREMATORY											
87d. LOCATION (City or Town) (County) (State)											
88. FUNERAL DIRECTOR											
88b. DATE											
88c. NAME OF CEMETERY OR CREMATORY											
88d. LOCATION (City or Town) (County) (State)											
89. FUNERAL DIRECTOR											
89b. DATE											
89c. NAME OF CEMETERY OR CREMATORY											
89d. LOCATION (City or Town) (County) (State)											
90. FUNERAL DIRECTOR											
90b. DATE											
90c. NAME OF CEMETERY OR CREMATORY											
90d. LOCATION (City or Town) (County) (State)											
91. FUNERAL DIRECTOR											
91b. DATE											
91c. NAME OF CEMETERY OR CREMATORY											
91d. LOCATION (City or Town) (County) (State)											
92. FUNERAL DIRECTOR											
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92c. NAME OF CEMETERY OR CREMATORY											
92d. LOCATION (City or Town) (County) (State)											
93. FUNERAL DIRECTOR											
93b. DATE											
93c. NAME OF CEMETERY OR CREMATORY											
93d. LOCATION (City or Town) (County) (State)											
94. FUNERAL DIRECTOR											
94b. DATE											
94c. NAME OF CEMETERY OR CREMATORY											
94d. LOCATION (City or Town) (County) (State)											
95. FUNERAL DIRECTOR											
95b. DATE											
95c. NAME OF CEMETERY OR CREMATORY											
95d. LOCATION (City or Town) (County) (State)											
96. FUNERAL DIRECTOR											
96b. DATE											
96c. NAME OF CEMETERY OR CREMATORY											
96d. LOCATION (City or Town) (County) (State)											
97. FUNERAL DIRECTOR											
97b. DATE											
97c. NAME OF CEMETERY OR CREMATORY											
97d. LOCATION (City or Town) (County) (State)											
98. FUNERAL DIRECTOR											
98b. DATE											
98c. NAME OF CEMETERY OR CREMATORY											
98d. LOCATION (City or Town) (County) (State)											
99. FUNERAL DIRECTOR											
99b. DATE											
99c. NAME OF CEMETERY OR CREMATORY											
99d. LOCATION (City or Town) (County) (State)											
100. FUNERAL DIRECTOR											
100b. DATE											
100c. NAME OF CEMETERY OR CREMATORY											
100d. LOCATION (City or Town) (County) (State)											

4124

1

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE 5-7-69

23c. NAME OF CEMETERY OR CREMATORY CHRIST CHURCH

23d. LOCATION (City or Town) (County) (State) GUILFORD MD

24. FUNERAL DIRECTOR

25a. REC'D BY REGISTRAR MAY 13 1969

25b. REGISTRAR'S SIGNATURE William Judge

26. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

26b. DATE

26c. NAME OF CEMETERY OR CREMATORY

26d. LOCATION (City or Town) (County) (State)

27. FUNERAL DIRECTOR

27b. DATE

27c. NAME OF CEMETERY OR CREMATORY

27d. LOCATION (City or Town) (County) (State)

28. FUNERAL DIRECTOR

28b. DATE

28c. NAME OF CEMETERY OR CREMATORY

28d. LOCATION (City or Town) (County) (State)

29. FUNERAL DIRECTOR

29b. DATE

29c. NAME OF CEMETERY OR CREMATORY

29d. LOCATION (City or Town) (County) (State)

30. FUNERAL DIRECTOR

30b. DATE

30c. NAME OF CEMETERY OR CREMATORY

30d. LOCATION (City or Town) (County) (State)

31. FUNERAL DIRECTOR

31b. DATE

31c. NAME OF CEMETERY OR CREMATORY

31d. LOCATION (City or Town) (County) (State)

32. FUNERAL DIRECTOR

32b. DATE

32c. NAME OF CEMETERY OR CREMATORY

32d. LOCATION (City or Town) (County) (State)

33. FUNERAL DIRECTOR

33b. DATE

33c. NAME OF CEMETERY OR CREMATORY

33d. LOCATION (City or Town) (County) (State)

34. FUNERAL DIRECTOR

34b. DATE

34c. NAME OF CEMETERY OR CREMATORY

34d. LOCATION (City or Town) (County) (State)

35. FUNERAL DIRECTOR

35b. DATE

35c. NAME OF CEMETERY OR CREMATORY

35d. LOCATION (City or Town) (County) (State)

36. FUNERAL DIRECTOR

36b. DATE

36c. NAME OF CEMETERY OR CREMATORY

36d. LOCATION (City or Town) (County) (State)

37. FUNERAL DIRECTOR

37b. DATE

37c. NAME OF CEMETERY OR CREMATORY

37d. LOCATION (City or Town) (County) (State)

38. FUNERAL DIRECTOR

38b. DATE

38c. NAME OF CEMETERY OR CREMATORY

38d. LOCATION (City or Town) (County) (State)

39. FUNERAL DIRECTOR

39b. DATE

39c. NAME OF CEMETERY OR CREMATORY

39d. LOCATION (City or Town) (County) (State)

40. FUNERAL DIRECTOR

40b. DATE

40c. NAME OF CEMETERY OR CREMATORY

40d. LOCATION (City or Town) (County) (State)

41. FUNERAL DIRECTOR

41b. DATE

41c. NAME OF CEMETERY OR CREMATORY

41d. LOCATION (City or Town) (County) (State)

42. FUNERAL DIRECTOR

42b. DATE

42c. NAME OF CEMETERY OR CREMATORY

42d. LOCATION (City or Town) (County) (State)

43. FUNERAL DIRECTOR

43b. DATE

43c. NAME OF CEMETERY OR CREMATORY

43d. LOCATION (City or Town) (County) (State)

44. FUNERAL DIRECTOR

44b. DATE

44c. NAME OF CEMETERY OR CREMATORY

44d. LOCATION (City or Town) (County) (State)

45. FUNERAL DIRECTOR

45b. DATE

45c. NAME OF CEMETERY OR CREMATORY

45d. LOCATION (City or Town) (County) (State)



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-13. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06691

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06689

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED			Month Day Year			2b HOUR			
Anna Lorena Whitcomb						May 30 1969			4 05 a.m.						
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			
Female		White		June 8, 1912		56 YRS						May 30 1969 4 05 a.m.			
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH			
Baltio. Co., Md.				U.S.A.								Baltimore Md			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (Give street address)				12a U.S.J.A. OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
Pikesville				1314 Reisterstown Rd.				Nurses Aide				Hospital Rosewood State			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Md.				Baltimore				Pikesville				13e STREET AND NUMBER			
												1314 Reisterstown Rd.			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
First Middle Last				First Middle Last											
Hugh Triplett				Mary Margaret Ridgley											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17. INFORMANT				ADDRESS			
No				None				217-163830				Mr. James K. Whitcomb, 1314 Reisterstown Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease												3 yrs.			
4124 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> none				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
				none 19											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				D. D. Caples				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
								M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				6-2-69			
EXAMINER'S NAME (Type)				D. D. Caples, M. D., 6 Hanover Rd., Reisterstown, Md. 21136				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				June 2, 1969		Druid Ridge Cemetery				Pikesville Baltio. Md.					
24 FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Frank H. Newell				Pikesville, Md.				JUN 2 1969				Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
06692										06690		
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
WILLIAM JOSEPH WHITE						Month Day Year			7:20 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		W		08-17-02			66 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
ENGLAND		U.S.				Baltimore Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			2a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore (Catersville)			Spring Grove State Hosp.									
13a. USUAL RESIDENCE (Where deceased lived 1 first 1 year before admission to State)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.			Balto.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		183 Cherrydell Rd.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
Not Known			Not Known									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT							
No			113-14-3164 A		Catherine White (wife) same address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4124 CARDIAC ARREST												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Constrictive Heart Failure.												
DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic C.V. disease												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Chronic Alcoholism.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			22e. DATE SIGNED			
Narciso W. Carmona M.D.			Narciso W. Carmona			Spring Grove S. Hospital			5/31/69			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(State)		
Burial			6/4/69		New Cathedral			Baltimore, Md				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Wm. Cook-Brooks West Inc Balt. Md. 21228			DATE JUN 3 1969			Charles Judge						



FOR STATE
HEALTH DEPT.

Item 2 Film 7/22/69 Maryland State Department of Health
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
06693 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06691

1 DECEASED NAME (Type or Print) First Middle Last Brenda Ann Wilhelm			2a DATE KNOWN OF DEATH Month Day Year MAY 28 1969			2b HOUR OF ESTIMATED DEATH 5:30 P.M.		
3 SEX F	4 RACE W	5 DATE OF BIRTH May 2 1962	6 AGE (in years last birthday) 7 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8 UNDER 24 HRS MONTHS DAYS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year MAY 28 1969
7a BIRTHPLACE (State or foreign country) Balto. Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.		
10. CITY OR TOWN OF DEATH Monkton			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Big Falls Rd.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.			13b. CITY OR TOWN Baltimore			13c. STREET AND NUMBER Big Falls Rd.		
14 FATHER'S NAME First Middle Last Charles R. Wilhelm			15 MOTHER'S MAIDEN NAME First Middle Last Doris Ann Naylor			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		
16b SOCIAL SECURITY NO —			17 INFORMANT Charles R. Wilhelm			18 ADDRESS Monkton Md 21111		
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1925 Neuroblastoma DUE TO, OR AS A CONSEQUENCE OF (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE C. M. France			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) A.M. FRANCE						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
						ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE May 31 1969			23c. NAME OF CEMETERY OR CREMATORY Monkton Meth. Cem.		
24. FUNERAL DIRECTOR James J. Hartenstein			ADDRESS New Freedom Pa.			23d. LOCATION (City or town) (County) (State) Monkton Balto. Md.		
25a. REC'D BY REGISTRAR JUN 2 1969			25b. REGISTRAR'S SIGNATURE William F. France			22b. DATE SIGNED 5/28/69		

1925- TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

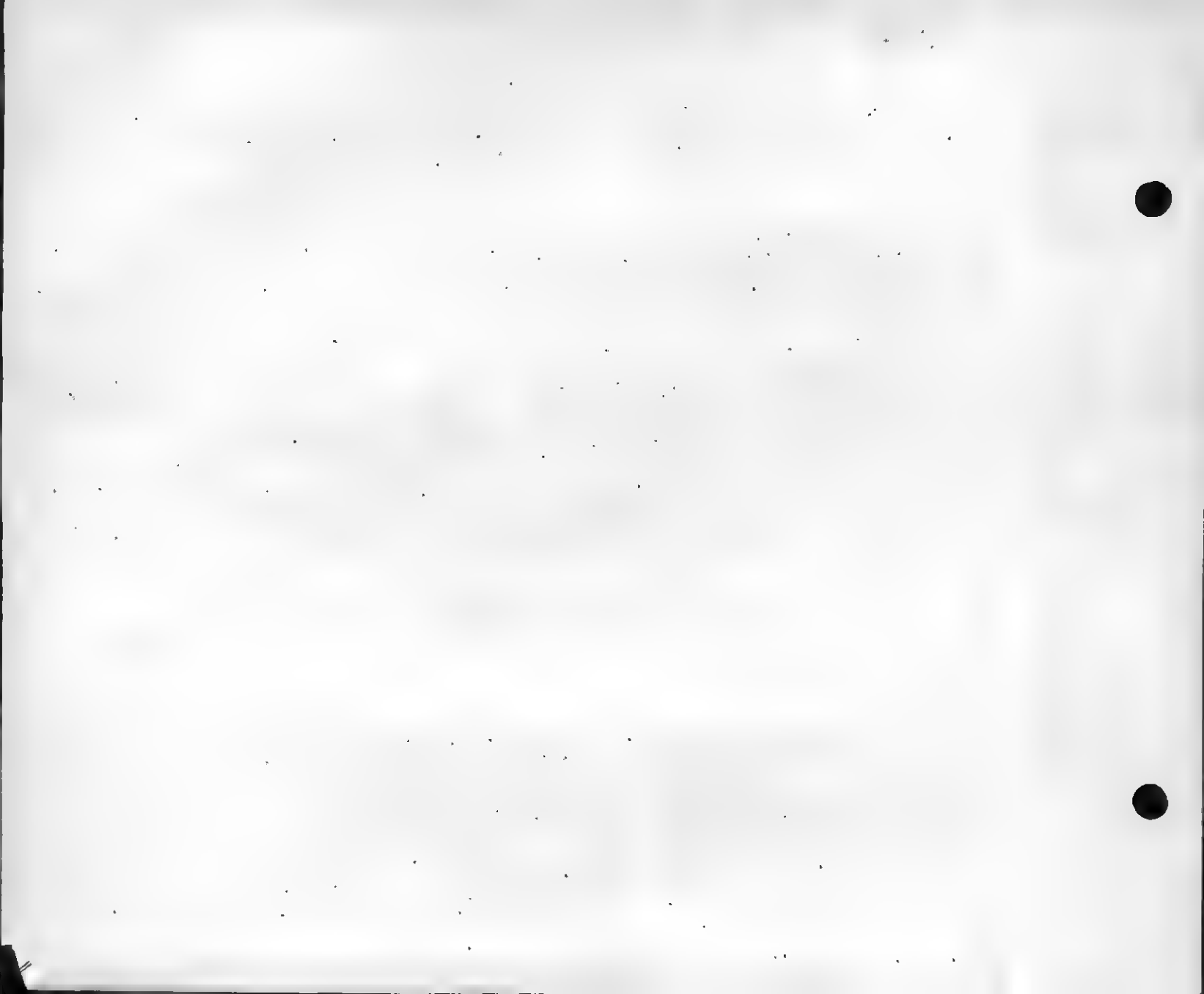
06694

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06692

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Elsie D. Wilhelm			2a. DATE OF DEATH May 11, 1969			2b. HOUR M				
3. SEX Female		4 RACE White		5 DATE OF BIRTH July 17, 1879		6. AGE (In years lost birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.				
10 CITY OR TOWN OF DEATH Stenleigh, Balto Co			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Armacost Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived admission) STATE Md			13b. CITY OR TOWN Balto			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 845 W 35th Street		
14. FATHER'S NAME First Middle Last Horace E Jones			15 MOTHER'S MAIDEN NAME First Middle Last Annie Federline							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 213 09 4596D			17 INFORMANT Evelyn Wilhelm			Address 845 W 35th St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Degeneration DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Pulmonary Edema 6 Months DUE TO, OR AS A CONSEQUENCE OF (c) Neuroles Mellitus 5 years PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from October 1965 to 5/11, 1969 , that (I) was lost saw the deceased alive on 5/11, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Chas F. O'Donnell						22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) Chas F. O'Donnell						22e. ADDRESS 7501 York Road				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE May 14, 1969			23c. NAME OF CEMETERY OR CREMATORY Lorraine Park			23d. LOCATION (City or Town) (County) (State) Baltimore, Md	
24. FUNERAL DIRECTOR Burgee Funeral Home						ADDRESS 3631 Falls Rd			25a. REC'D BY REGISTRAR MAY 16 1969	
									25b. REGISTRAR'S SIGNATURE J. H. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-1-64
304A REV. 5-68

06695

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06693

1. DECEASED NAME (Type or print) EMORY		First R.		Middle WILHELM		Last		2a. DATE OF DEATH 5 Month 20 Day 69 Year			2b. HOUR 4:00 AM		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MAY 8, 1901			6 AGE (In years last birthday) 68		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Hampstead, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md							
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED CRANE OPERATOR			12b. KIND OF BUSINESS OR INDUSTRY STEEL						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY —		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 745 N. KENWOOD AVE.					
14 FATHER'S NAME First HOWARD Middle WILHELM		15. MOTHER'S MAIDEN NAME First ALICE Middle ?											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO 216-10-1994		17. INFORMANT MRS. CATHERINE E. WILHELM		Address (SAME)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia													
DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) (b) following right radical neck operation													
DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic carcinoma of neck													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic pulmonary emphysema and hypertensive heart disease													
19a. DATE OF OPERATION 5/15/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Metastatic ca. of neck		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from April 12, 1969 to May 20, 1969 , that (I) (we) last saw the deceased alive on May 20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Rudiger Breiteneker, M.D.		DEGREE —		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/20/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 6701 N. Charles Street											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/23/69		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION (City or Town) (County) (State) BALTO., Md.							
24. FUNERAL DIRECTOR J. Walter Cullen		ADDRESS 5444 BELAIR Rd.		25a. REC'D BY REGISTRAR DATE MAY 23 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL-DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

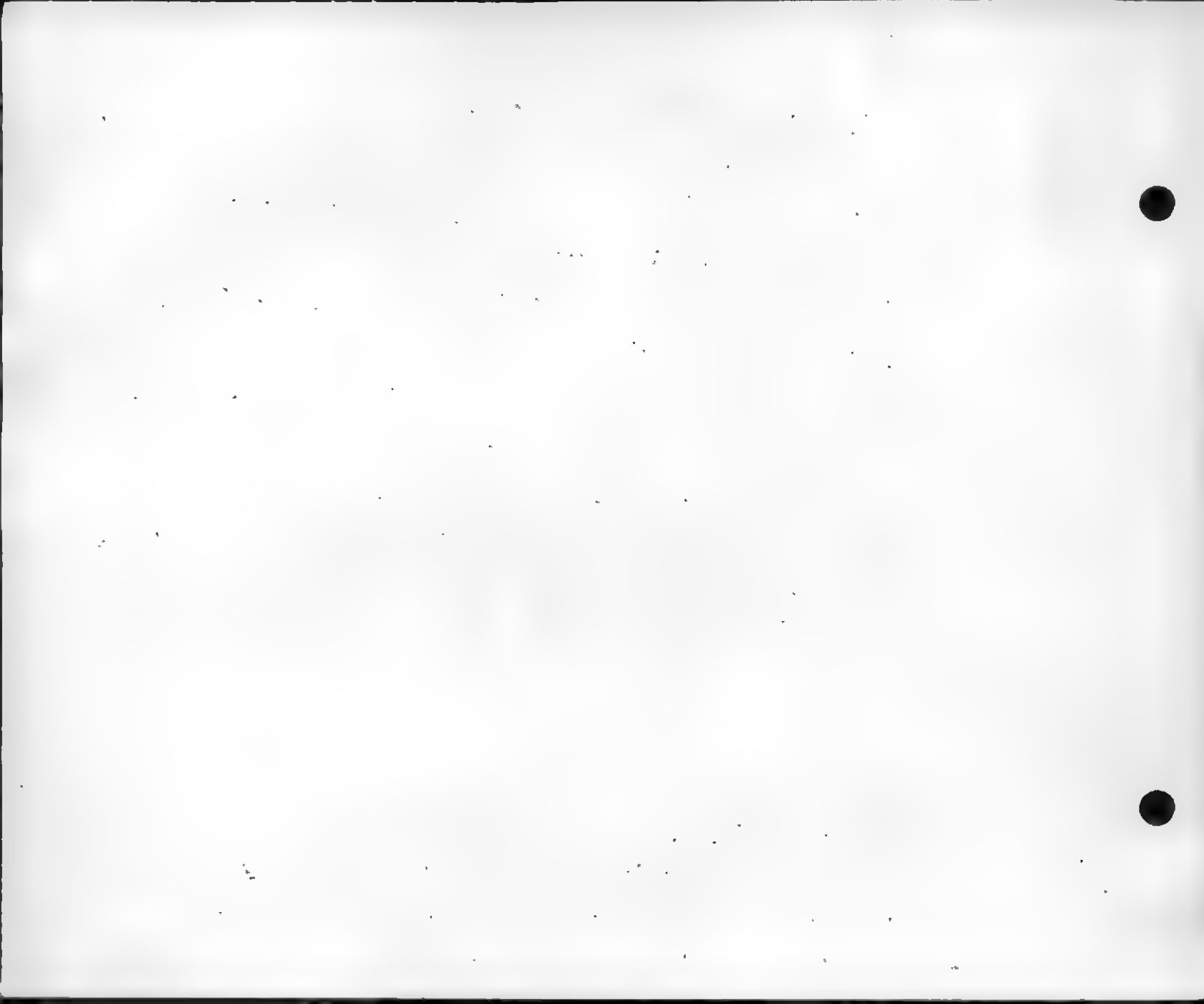
1

06696

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06694

1. DECEASED-NAME (Type or print) First Middle Last <i>John Williams</i>			2a. DATE OF DEATH Month Day Year <i>5 3 1969</i>			2b. HOUR M <i>11 P</i>	
3 SEX <i>Male</i>		4 RACE <i>Negro</i>		5. DATE OF BIRTH <i>1-8-86</i>		6. AGE (In years lost birthday) <i>83</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore County</i> Md.	
10. CITY OR TOWN OF DEATH <i>Mount Wilson</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Mt. Wilson State Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE <i>MD.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>John Williams</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Irene Dougherty</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO <i>214-24-7767</i>		17. INFORMANT Address <i>Records, Mt. Wilson State Hospital</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of prostate</i> <i>185x</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastasis of bladder</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic cardiovascular diseases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>Moderately ADV. Pul & b - in active</i>							
19a. DATE OF OPERATION <i>1-10-69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>P.U.R. of prostate</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. / Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W Newcomer</i>						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>William Newcomer, M D.</i>						22e. ADDRESS <i>Mount Wilson, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-9-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Ba/te. Md</i>	
24. FUNERAL DIRECTOR <i>Wm C March</i>				ADDRESS <i>928 E. North Ave</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 8 1969</i>	
25b. REG STRAR'S SIGNATURE <i>Charles J. Under</i>							

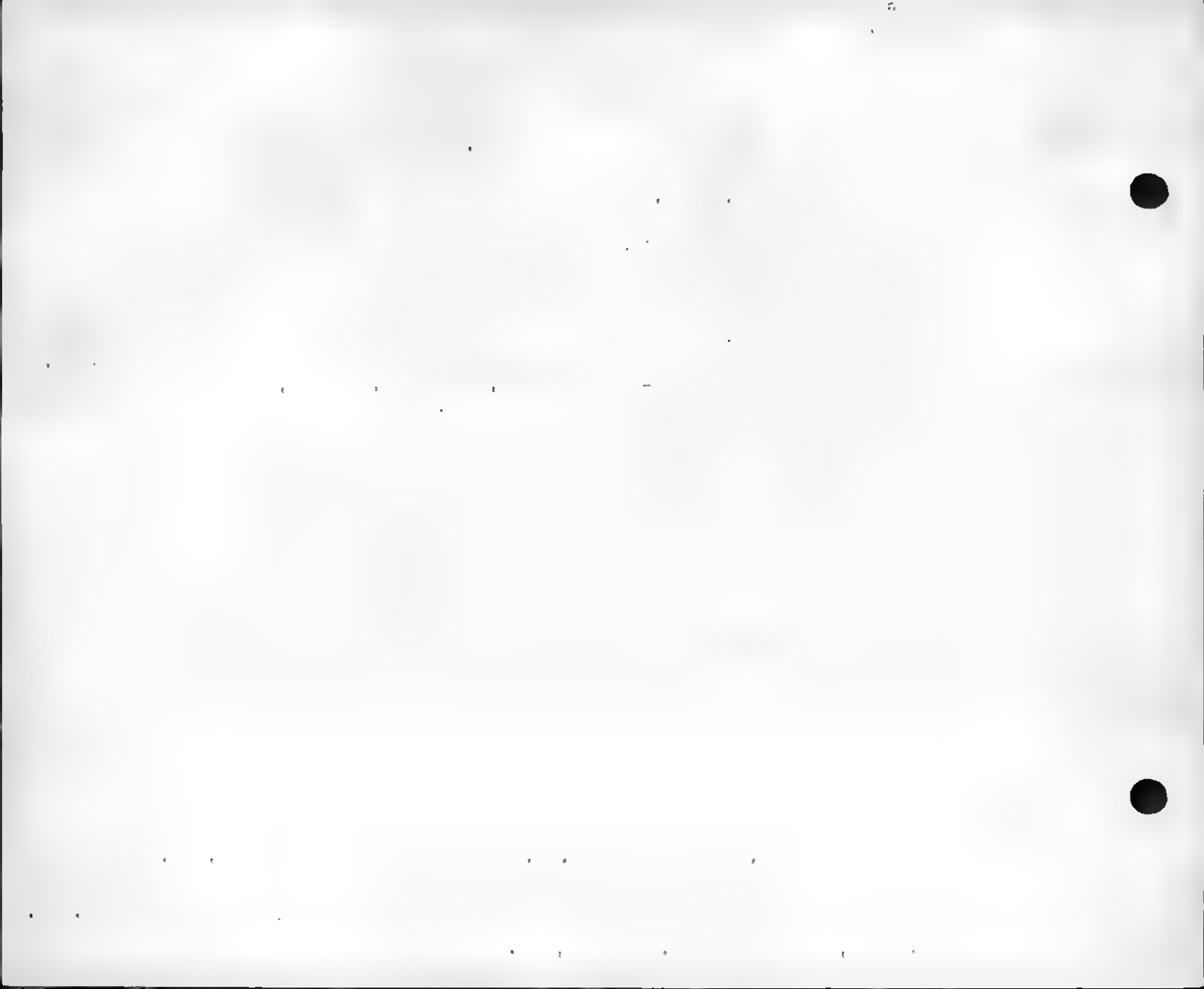


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> 06697 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06695 </div>										
1. DECEASED NAME (Type or print) Lucy				Middle Anderson		Last Williams		2a. DATE OF DEATH Month May Day 3 Year 1969		2b. HOUR M
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 10, 1879		6. AGE (in years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2628 Liberty Parkway		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2628 Liberty Parkway		
14. FATHER'S NAME First William Middle S. Last Anderson				15. MOTHER'S MAIDEN NAME First Mittie Middle Ella Last Schelhorse						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 224-66-8909J		17. INFORMANT (Daughter) Address Dundalk, Md. Mrs. Nannie E. Easley, 2628 Liberty Parkway						
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Semility</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 11, 1969</u> to <u>May 5, 1969</u> , that (I) (we) lost saw the deceased alive on <u>May 5, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <u>Benigno R. Lazaro</u>				DEGREE M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/5/69		
22d. PHYSICIAN'S NAME (Type) Benigno R. Lazaro		22e. ADDRESS 59 Dundalk Ave. Dundalk, Md. 21222								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/7/69		23c. NAME OF CEMETERY OR CREMATORY Williams Family Cemetery			23d. LOCATION (City or Town) (County) (State) Chatham, Pittsylvania Co. Va.			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE MAY 8 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				



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06698

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06696

Item 2a Film 413 5/29/69 kk

1 DECEASED NAME (Type or print) First Middle Last <i>Alice G Wilson</i>			2a. DATE OF DEATH Month Day Year <i>5 17 1969</i>			2b HOUR <i>3:40</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>5-11-12</i>		6 AGE (in years last birthday) <i>57</i> YRS.	
7a BIRTHPLACE (State or foreign country) <i>Delaware</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i>	
10 CITY OR TOWN OF DEATH <i>Towson</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Chesapeake Manor</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Sales clerk</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased administered) STATE <i>Md.</i>		13b COUNTY <i>Baltimore</i>		13c CITY OR TOWN <i>Baltimore</i>		13d INS DE CITY, JM 15? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First Middle Last <i>Palmer D Guest</i>		15. MOTHER'S M A DEN NAME First Middle Last <i>Ethel Hobson</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO <i>214-24-0901</i>	
17 INFORMANT <i>Stanley N. Wilson</i>		18 ADDRESS <i>Baltimore, Md.</i>		19 STREET AND NUMBER <i>838 E. Belvedere Ave</i>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma Pancreatic origin</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>6 mos</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
9a DATE OF OPERATION <i>Extremity Snp</i>		9b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year <i>5 16 P.M. 1969</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>August, 1948</i> , to <i>5/17, 1969</i> , that (I) (we) last saw the deceased alive on <i>5/16</i> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Newland Edward Day</i>		22c DATE SIGNED <i>May 19, 1969</i>		22d PHYSICIAN'S NAME (Type) <i>Newland Edward Day MD</i>		22e ADDRESS <i>4-E-33rd St Balto Md</i>	
23a BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b DATE <i>5/20/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Newark Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Newark, Delaware</i>	
24 FUNERAL DIRECTOR <i>R.T. Jones</i>		24b ADDRESS <i>Newark, Del.</i>		25a REC'D BY REGISTRAR <i>MAY 23 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

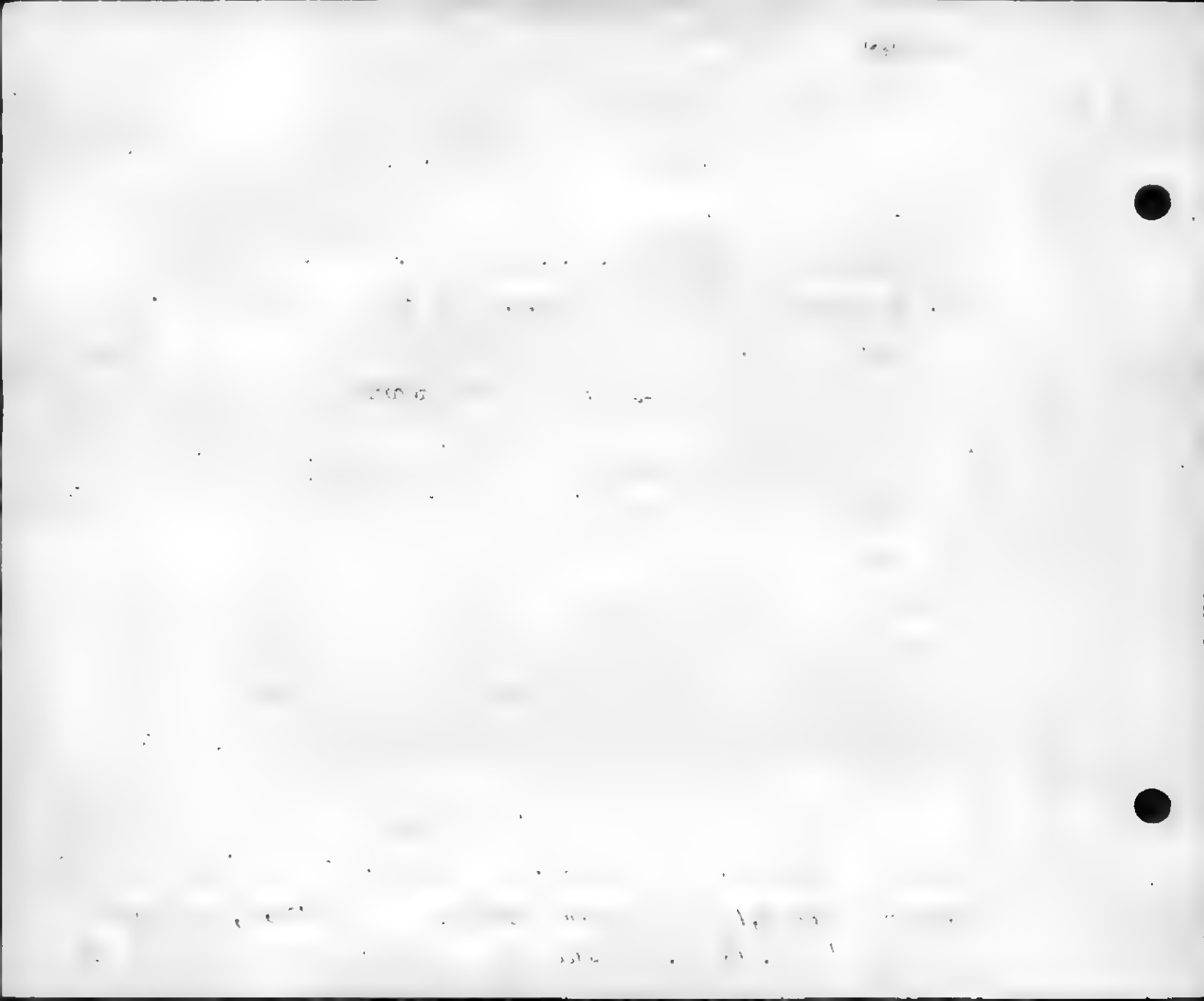


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VR A 134
30M REV. 1/78

06699										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06697																													
1. DECEASED NAME (Type or print) First Middle Last Irene Slaten Wilson										2a. DATE OF DEATH Month Day Year May 25 1969										2b. HOUR PM 1:15																													
3. SEX Female										4. RACE Caucasian										5. DATE OF BIRTH August 2, 1880										6. AGE (In years lost birth-day) 88 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) California										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore County Md.																			
10. CITY OR TOWN OF DEATH Lutherville										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) College Manor, Seminary Ave.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Gov't. Accountant										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Dist. of Columbia										13b. COUNTY N.W.										13c. CITY OR TOWN N.W.										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 3002 Rodman St.									
14. FATHER'S NAME First Middle Last Francis M. Slaten										15. MOTHER'S MAIDEN NAME First Middle Last Irene Henry										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No										16b. SOCIAL SECURITY NO. 577-44-4770										17. INFORMANT Family records Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 6/16, 1961 to 5/25/69 , that (I) (we) last saw the deceased alive on 5-25-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE RK Gundry MD										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 5/26/69																													
22d. PHYSICIAN'S NAME (Type) Richard K. Gundry, M.D.										22e. ADDRESS 2 W. University Pkwy. 21218																																							
23a. BURIAL CREMATION, REMOVAL (Specify) Cremation										23b. DATE May 26, 1969										23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery										23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland																			
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland										ADDRESS										25a. REC'D BY REGISTRAR DATE MAY 29 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in permanent item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1042. Page 5 may be retained for your files.

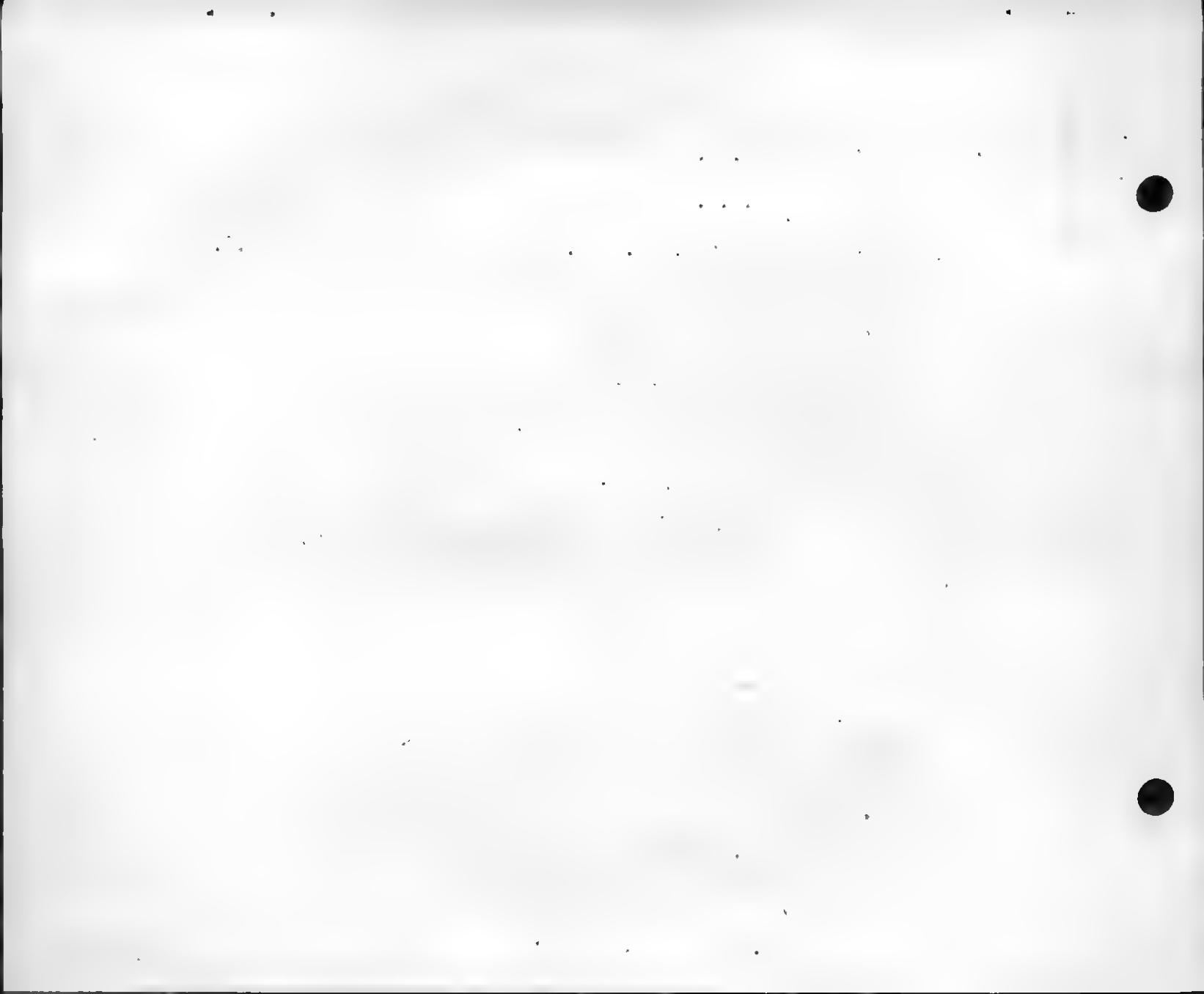
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06700

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06698

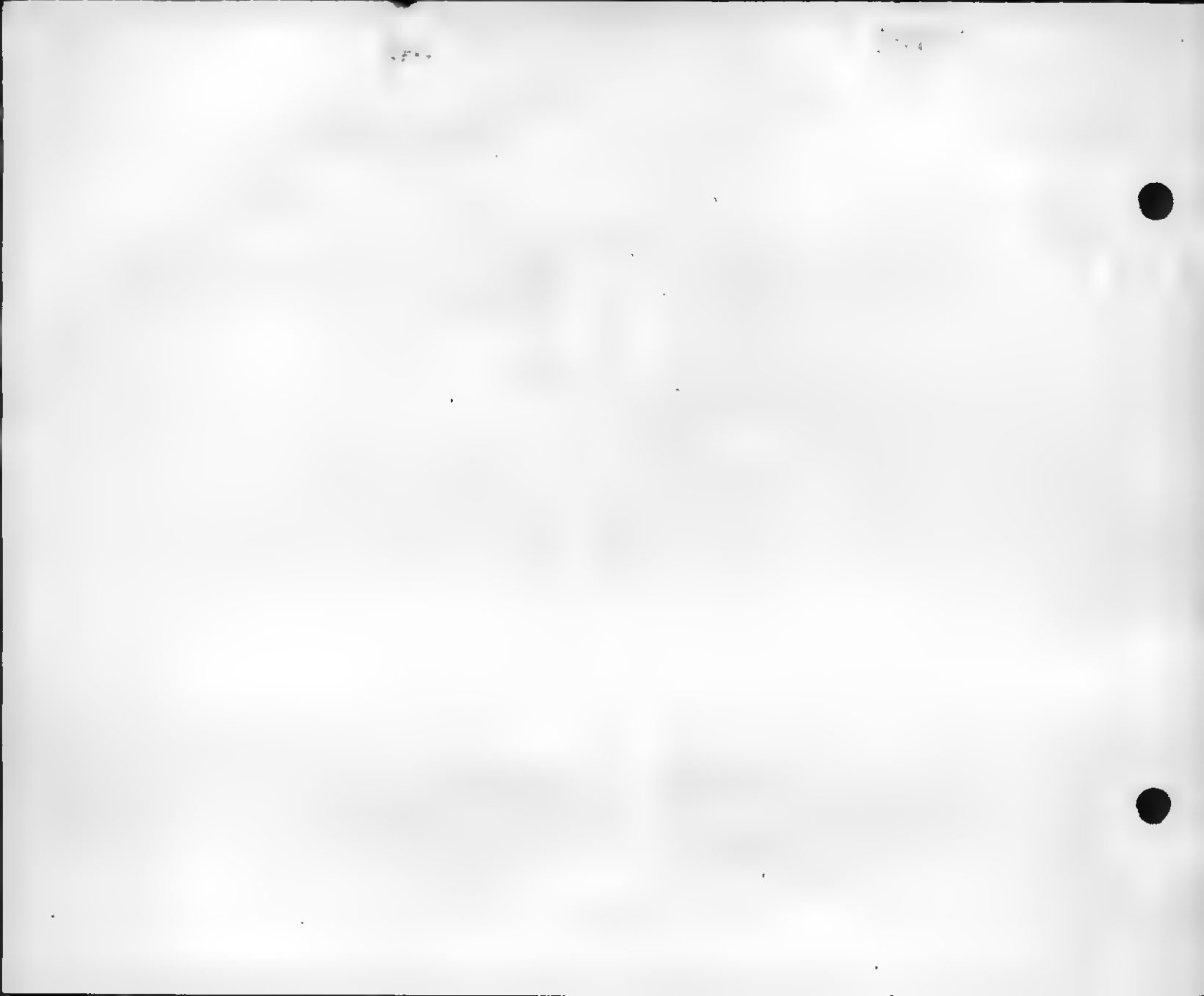
1 DECEASED NAME (Type or Print)			First	Middle	Last	2c. DATE KNOWN OF DEATH ESTI- MATED				Month	Day	Year	2b HOUR
James			Gary	Wilson	2c. DATE KNOWN OF DEATH ESTI- MATED				5	1	1969	M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS MONTHS	YEAR	8 UNDER 24 HRS HOURS	MIN.	2c. DATE PRONOUNCED DEAD				2d HOUR	
Male	White	Jan. 12, 1877	92 YRS					Month				Day	Year
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				M	
Maryland			U.S.A.		Baltimore			Baltimore				Id	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Baltimore			Balt. Co. Gen. Hospital			Retired D.O. R.N.							
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d. HSIDE CITY LIMITS?		13e STREET AND NUMBER				
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3606 Sylvan Dr				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
?			Wilson			Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS				
No			705-05-7817			Mrs Catherine V Wilson			6201 Loch Raven Blvd				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Broncho pneumonia</u>												<u>after 3 days</u>	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) <u>Fell in his home on PM had 2 linear fractures</u>												<u>in 4-28-69</u>	
DUE TO, OR AS A CONSEQUENCE OF <u>fracture wing of pelvis and</u>													
<u>pelvic bone and small left distal humerus</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)													
<u>Eccymosis of right calf & face. small laceration of face.</u>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?							
no			no			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month Day Year HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
			4-28-69 P.M.			at Back Gate Sun. 1/4/69							
21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21c LOCATION Street or R.F.D. No			City or Town				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			Robert B. Taylor M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED				
EXAMINER'S NAME (Type)			Robert B. Taylor			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			5-2-69				
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE		23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)			(County)	(State)	
Burial			5/5/69		New Cathedral Cemetery			Baltimore			Maryland		
24. FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE				
Leonard J Ruck Inc. Baltimore, Maryland						MAY 5 1969			Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13e by Phone to Inform MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 7 Film 412 5/9/69 kk CERTIFICATE OF DEATH 06699													
1. DECEASED NAME (Type or print) William H Wilson						2a. DATE OF DEATH May Month 2 Day 1969				2b. HOUR M			
3. SEX M		4. RACE W		5. DATE OF BIRTH Oct 1, 1881			6. AGE (In years) 87 88 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 		
7a. BIRTHPLACE (State or foreign country) England			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md		
10. CITY OR TOWN OF DEATH Catonsville				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Forest Haven Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Foreman			12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		3d. INSIDE CITY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3309 Benson Ave. 315 Ingleside Avenue				
14. FATHER'S NAME First Unknown Middle Last 						15. MOTHER'S MAIDEN NAME First Unknown Middle Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (yes give war or dates of service)				16b. SOCIAL SECURITY NO. 220-01-4890		17. INFORMANT Ethel Y. Livesay Address 3808 Benson Ave 21227							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Embolism 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a) 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State 							
22a. I certify that (I) (this hospital) attended the deceased from 1/20, 1969 , to 5/11, 1969 , that (I) (we) last saw the deceased alive on 5/11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE John H. Shaw						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/14/69					
22d. PHYSICIAN'S NAME (Type) John H. Shaw						22e. ADDRESS 5800 Edmondson Avenue							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5-5-69		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City or Town) Balto. City (County) Baltimore (State) Md.					
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229						25a. REC'D BY REG. STR. DMV		25b. REGISTRAR'S SIGNATURE Charles Judge					



4/22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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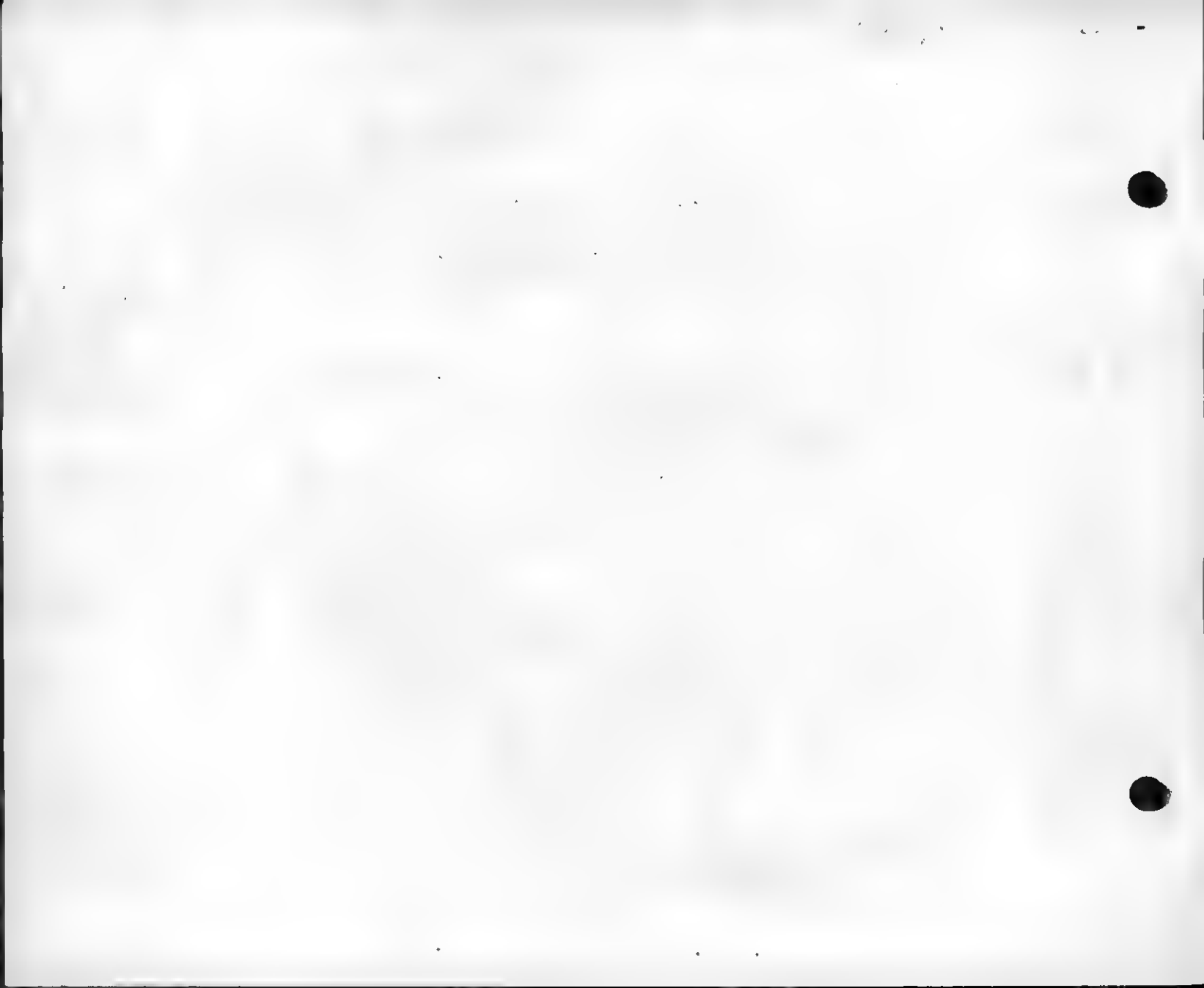
2

06702

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06700

1 DECEASED NAME (Type or print) SARAH		First	Middle	Last	2a. DATE OF DEATH Month 5 Day 14 Year 69		2b. HOUR 1 A.M.	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH XXXXXX		6 AGE (in years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10 CITY OR TOWN OF DEATH Randallstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY Balto		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8340 Church Lane APT 203
14 FATHER'S NAME First MORRIS Middle GOLDSTEIN Last GOLDSTEIN		15 MOTHER'S MAIDEN NAME First RACHAEL Middle GOLDSTEIN Last GOLDSTEIN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT MRS. DOROTHY BRENNER Address 8340 CHURCH LANE, APT. 203				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4-26-1969 , to 5-14-1969 , that (I) (we) last saw the deceased alive on 5-14-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Fausto Q. Aquino, Jr. DEGREE ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. DIRECTOR PHYS. PHYS.				22c. DATE SIGNED 5-14-69				
22d. PHYSICIAN'S NAME (Type) FAUSTO Q. AQUINO JR.				22e. ADDRESS BALTO. COUNTY GEN. HOSP.				
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-15-69		23c. NAME OF CEMETERY OR CREMATORY BETH JACOB ANSHE VESHEAR		23d. LOCATION (City or Town) (County) (State) ROSEDALE, MARYLAND		
24 FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD. ADDRESS				25a. REC'D BY REGISTRAR DATE MAY 19 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



CERTIFICATE OF DEATH

06703

06701

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M
Emma				Wright	May 27 1969		
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female	White		April 16, 1898		71 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.
Czechoslovakia	U.S.A.				Baltimore		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Dundalk		8006 Wynbrook Rd		Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS DE CITY, LHM, TS?	
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		13e. STREET AND NUMBER			
First Middle Last		First Middle Last		8006 Wynbrook Rd			
? ? Link		? ? ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address	
No		217-48-1576		Mr Joseph A Bem		203 North Branch Rd	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Heart failure</i>							<i>unknown</i>
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) <i>Rheumatic heart disease</i>							<i>since childhood</i>
(b) <i>stating the underlying cause last.</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug</i> , 19 <i>68</i> , to <i>Sept</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Sept</i> , 19 <i>68</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. MED. DEGREE		22d. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22e. DATE SIGNED	
<i>B.W. Sollod</i>						<i>5-27-69</i>	
22a. PHYSICIAN'S NAME (Type)		22b. ADDRESS		22c. DATE SIGNED			
B.W. Sollod M.D.		2900 Dunran Rd Baltimore, Md 21222					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5/31/69		Parkwood		Baltimore, Maryland	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J Ruck Inc. Baltimore, Maryland				JUN 2 1969		<i>W. L. Linder</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

06704

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06702

1. DECEASED NAME (Type or Print) JOHN H. WUESTLAND			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month MAY Day 30 Year 1969			2b. HOUR 1 A M		
3. SEX M	4. RACE W	5. DATE OF BIRTH 2/13/06	6. AGE (in years last birthday) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month MAY Day 30 Year 1969			2d. HOUR 10 40 M		
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.			Md		
10. CITY OR TOWN OF DEATH ESSEX			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 1454 KENT RD.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE MD.			13b. COUNTY BALTO.		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1454 KENT RD		
14. FATHER'S NAME First Middle Last GEO. WUESTLAND			15. MOTHER'S M A D E N NAME First Middle Last KING								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK			16b. SOCIAL SECURITY NO (if yes give war or dates of service)		17. INFORMANT DOROTHY BREGAL			ADDRESS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H-S-C-V-Disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year 19 HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE MELVIN B. DAVIS			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 6/2/69		
EXAMINER'S NAME (Type) MELVIN B. DAVIS M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>		
						ADDRESS (Street, city, town or county) 6800 MORNINGTON RD DONALD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/2/69		23c. NAME OF CEMETERY OR CREMATORY ST. MATTHEWS			23d. LOCATION (City or Town) (County) (State) BALTO. MD.				
24. FUNERAL DIRECTOR J.G. CONNELLY SONS			ADDRESS 300 MACE			25a. REC'D BY REGISTRAR JUN 4 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

4124

DIVISION OF VITAL RECORDS, 701 W. PINESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06705

CERTIFICATE OF DEATH

06703

1. DECEASED NAME (Type or print) NATHANIEL JEROME		First JEROME	Middle NATHANIEL	Last ZIFF	2a. DATE OF DEATH Month MAY Day 17 Year 1969		2b. HOUR 1 p.m.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-1-1898		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND BALTO.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		Md.	
10. CITY OR TOWN OF DEATH TOWSON 4		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MD. RACING COMMISS.		12b. KIND OF BUSINESS OR INDUSTRY CLERK			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8306 NUNLEY DRIVE. APT. C	
14. FATHER'S NAME First JACOB Middle B. Last ZIFF		15. MOTHER'S MAIDEN NAME First ANNA Middle NESLONE Last NESLONE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, on or after (date) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT MRS. REGINA A. ZIFF, 8306 NUNLEY DRIVE, APT. C	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage 4319 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 5-17 , 19 69 , to 5-17 , 19 69 , that (X) (we) last saw the deceased alive on May 17 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Reynaldo Orjela - Gomez, M.D.		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED MAY 17, 1969			
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjela - Gomez, M.D.		22e. ADDRESS 7620 York Road, Towson 4, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-20-69		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR DATE MAY 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

00703

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 Film 413

6/3/69 kk

06706

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06704

1. DECEASED NAME (Type or Print) LUCKY HAYES ZOPP			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 19			2b. HOUR M		
3. SEX male	4. RACE white	5. DATE OF BIRTH Mar 31, 1953	6. AGE (In years last birthday) 16 YRS	IF UNDER 1 YEAR MONTHS 16 DAYS 16 HOURS 16 MIN.		2c. DATE PRONOUNCED DEAD Month May Day 25 Year 1969		2d. HOUR 5:27 P.M.
7a. BIRTHPLACE (State or foreign country) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY --
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER 3509 Falls Road		
14. FATHER'S NAME First Middle Last Robert B Zopp			15. MOTHER'S MAIDEN NAME First Middle Last Fleshman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) N/A			17. INFORMANT ADDRESS Mr. Robert B. Zopp 3509 Falls Road 21211		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF (b) 9109 DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. UNK M. UNK 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subj. drowned			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Lake Roland		21f. LOCATION Street or R.F.D. No. City or Town County State Baltimore, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 5/26/69		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE May 28, 1969		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville Md.	
24. FUNERAL DIRECTOR A. Alan Spitz 8146 36th St.			25a. REC'D BY REGISTRAR MAY 29 1969			25b. REGISTRAR'S SIGNATURE W. L. Jones		

SECRET

100-100000

W. Virginia

STANDARD

Robert R. Scott

Mr. Robert R. Scott, 100-100000

WVA

100

Handwritten signature

STANDARD

100-100000

SECRET

MAY 21 1961